

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet S Parts I-III Date/Time Prepared: 10/24/2019 1:36 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 10/24/2019	Time: 1:36 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LOUIS A. WEISS MEMORIAL HOSPITAL (14-0082) for the cost reporting period beginning 01/29/2019 and ending 05/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	419,980	120,325	0	0	1.00
2.00	Subprovider - IPF	0	0	-1		0	2.00
3.00	Subprovider - IRF	0	-33,412	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	386,568	120,324	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0082		Period: From 01/29/2019 To 05/31/2019		Worksheet S-2 Part I Date/Time Prepared: 10/24/2019 1:36 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 4646 NORTH MARINE DRIVE			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60640		County: COOK		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		LOUIS A. WEISS MEMORIAL HOSPITAL	140082	16974	1	07/01/1966	N	P	N
4.00	Subprovider - IPF		PSYCH UNIT	14S082	16974	4	06/01/2003	N	P	N
5.00	Subprovider - IRF		REHABILITATION UNIT	14T082	16974	5	07/01/1996	N	P	N
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/29/2019	05/31/2019		20.00
21.00	Type of Control (see instructions)						4			21.00
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			254	16	12	2	1,410	229	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0082		Period: From 01/29/2019 To 05/31/2019		Worksheet S-2 Part I Date/Time Prepared: 10/24/2019 1:36 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	122		25.00
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2	05/31/2018		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)									37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.									38.00
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						Y	N		40.00
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
						1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)						N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-2
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					Y	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		3.10	26.26	0.105586		64.00

Worksheet S-2
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

MCRIF32 - 15.8.166.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet S-2 Part I Date/Time Prepared: 10/24/2019 1:36 pm
			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	Y	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
				4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00

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		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	3,374,260	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0082		Period: From 01/29/2019 To 05/31/2019		Worksheet S-2 Part I Date/Time Prepared: 10/24/2019 1:36 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00		
142.00	Street:	PO Box:						142.00		
143.00	City:	State:			Zip Code:			143.00		
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N		N		N		N		155.00
156.00	Subprovider - IPF	N		N		N		N		156.00
157.00	Subprovider - IRF	N		N		N		N		157.00
158.00	SUBPROVIDER									158.00
159.00	SNF	N		N		N		N		159.00
160.00	HOME HEALTH AGENCY	N		N		N		N		160.00
161.00	CMHC			N		N		N		161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00	
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					01/01/2017	03/31/2017		170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet S-2 Part II Date/Time Prepared: 10/24/2019 1:36 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	01/29/2019		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N	A	01/15/2020	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/07/2019	Y	10/07/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-2
Part II
Date/Time Prepared:
10/24/2019 1:36 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TAD	ERICKSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	TRE REIMBURSEMENT CONSULTING, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(602) 799-2223	TAD@TRERCI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-2
Part II
Date/Time Prepared:
10/24/2019 1:36 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRESIDENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-3
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	103	12,669	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		103	12,669	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	1,968	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		119	14,637	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	11	1,353		0	16.00
17.00 SUBPROVIDER - IRF	41.00	14	1,722		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		144			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-3
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,656	200	6,978			1.00
2.00	HMO and other (see instructions)	1,328	1,669				2.00
3.00	HMO IPF Subprovider	107	54				3.00
4.00	HMO IRF Subprovider	57	122				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,656	200	6,978			7.00
8.00	INTENSIVE CARE UNIT	417	54	978			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,073	254	7,956	82.82	307.34	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	584	14	939	0.00	12.01	16.00
17.00	SUBPROVIDER - IRF	367	0	675	0.00	5.87	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				82.82	325.22	27.00
28.00	Observation Bed Days		23	804			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-3
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	635	48	1,747	1.00
2.00 HMO and other (see instructions)			237	325		2.00
3.00 HMO IPF Subprovider				6		3.00
4.00 HMO IRF Subprovider				10		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	635	48	1,747	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	46	1	79	16.00
17.00 SUBPROVIDER - IRF	0.00	0	28	0	52	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-3
Part II
Date/Time Prepared:
10/24/2019 1:36 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	15,504,410	0	15,504,410	444,395.74	34.89	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		154,823	0	154,823	1,581.12	97.92	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	1,718,816	0	1,718,816	54,704.52	31.42	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,303,058	0	1,303,058	31,789.90	40.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		179,055	0	179,055	2,912.96	61.47	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,423,092	0	2,423,092			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		240,705	0	240,705			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		1,981	0	1,981			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		207,151	0	207,151			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	29,193	0	29,193	894.67	32.63	26.00
27.00	Administrative & General	5.00	1,483,702	0	1,483,702	38,901.47	38.14	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-3
Part II
Date/Time Prepared:
10/24/2019 1:36 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		69,242	0	69,242	1,067.99	64.83	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	465,732	0	465,732	16,278.64	28.61	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	302,255	0	302,255	17,655.08	17.12	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	295,994	0	295,994	16,703.95	17.72	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	277,288	0	277,288	6,164.70	44.98	38.00
39.00	Central Services and Supply	14.00	108,823	0	108,823	4,871.22	22.34	39.00
40.00	Pharmacy	15.00	430,867	0	430,867	9,939.26	43.35	40.00
41.00	Medical Records & Medical Records Library	16.00	131,297	0	131,297	3,756.71	34.95	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-3
Part III
Date/Time Prepared:
10/24/2019 1:36 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	13,700,013	0	13,700,013	389,178.09	35.20	1.00
2.00	Excluded area salaries (see instructions)	1,303,058	0	1,303,058	31,789.90	40.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)	12,396,955	0	12,396,955	357,388.19	34.69	3.00
4.00	Subtotal other wages & related costs (see inst.)	179,055	0	179,055	2,912.96	61.47	4.00
5.00	Subtotal wage-related costs (see inst.)	2,423,092	0	2,423,092	0.00	19.55	5.00
6.00	Total (sum of lines 3 thru 5)	14,999,102	0	14,999,102	360,301.15	41.63	6.00
7.00	Total overhead cost (see instructions)	3,594,393	0	3,594,393	116,233.69	30.92	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 10/24/2019 1:36 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		155,283	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		1,014,020	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		22,964	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		-9,011	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		54,191	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		312,171	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		782,864	17.00
18.00	Medicare Taxes - Employers Portion Only		192,425	18.00
19.00	Unemployment Insurance		315,570	19.00
20.00	State or Federal Unemployment Taxes		31,904	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		548	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		2,872,929	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet S-3
Part V
Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	179,055	2,872,929	1.00
2.00	Hospital	179,055	2,872,929	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet S-10

Date/Time Prepared:
10/24/2019 1:36 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.150291	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		5,716,982	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		587,512	5.00
6.00	Medicaid charges		53,627,473	6.00
7.00	Medicaid cost (line 1 times line 6)		8,059,727	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,755,233	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,755,233	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,371,644	117,429	4,489,073
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	657,019	117,429	774,448
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	657,019	117,429	774,448
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,532,665	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		431,243	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		663,451	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,869,214	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		513,134	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,287,582	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,042,815	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet A

Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		489,649	489,649	1,753,371	2,243,020 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		336,760	336,760	290,923	627,683 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,193	1,938,696	1,967,889	-3,310	1,964,579 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,483,702	6,201,536	7,685,238	-1,574,386	6,110,852 5.00
7.00	00700	OPERATION OF PLANT	465,732	1,946,665	2,412,397	-646	2,411,751 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	100,141	100,141	1,054	101,195 8.00
9.00	00900	HOUSEKEEPING	302,255	122,454	424,709	-15,059	409,650 9.00
10.00	01000	DIETARY	295,994	312,757	608,751	-5,428	603,323 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	277,288	26,950	304,238	0	304,238 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,823	453,092	561,915	-50,813	511,102 14.00
15.00	01500	PHARMACY	430,867	964,500	1,395,367	-880,020	515,347 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,297	60,274	191,571	3,884	195,455 16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,718,816	41,738	1,760,554	0	1,760,554 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	749,485	749,485	-568	748,917 22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,931,061	579,686	3,510,747	-64,273	3,446,474 30.00
31.00	03100	INTENSIVE CARE UNIT	765,894	169,921	935,815	-37,964	897,851 31.00
40.00	04000	SUBPROVIDER - IPF	386,637	30,460	417,097	-1,325	415,772 40.00
41.00	04100	SUBPROVIDER - IRF	336,299	29,027	365,326	-2,002	363,324 41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,054,787	2,960,761	4,015,548	-1,659,008	2,356,540 50.00
50.01	03340	GASTRO INTESTINAL SERVICES	109,050	60,825	169,875	-8,471	161,404 50.01
51.00	05100	RECOVERY ROOM	133,648	58,259	191,907	-9,914	181,993 51.00
53.00	05300	ANESTHESIOLOGY	35,301	509,376	544,677	-12,118	532,559 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	468,946	218,109	687,055	-70,672	616,383 54.00
54.01	03630	ULTRA SOUND	72,128	14,545	86,673	-5,330	81,343 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	97,657	122,842	220,499	-36,435	184,064 55.00
56.00	05600	RADIOISOTOPE	64,112	107,030	171,142	-188	170,954 56.00
56.01	03650	VASCULAR LAB	53,237	112,932	166,169	-201	165,968 56.01
56.02	03950	STRAUSS ONCOLOGY	144,483	927,712	1,072,195	-879,307	192,888 56.02
57.00	05700	CT SCAN	104,962	25,091	130,053	-1,482	128,571 57.00
58.00	05800	MRI	36,070	1,243	37,313	-263	37,050 58.00
59.00	05900	CARDIAC CATHETERIZATION	144,994	160,196	305,190	-104,514	200,676 59.00
60.00	06000	LABORATORY	394,730	522,665	917,395	-157	917,238 60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	148,495	148,495	0	148,495 63.00
65.00	06500	RESPIRATORY THERAPY	371,239	148,889	520,128	-63,241	456,887 65.00
66.00	06600	PHYSICAL THERAPY	562,340	49,241	611,581	-833	610,748 66.00
69.00	06900	ELECTROCARDIOLOGY	172,563	28,894	201,457	-2,604	198,853 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,769	711	16,480	0	16,480 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	209,252	209,252 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,619,605	1,619,605 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,802,861	1,802,861 73.00
74.00	07400	RENAL DIALYSIS	0	186,376	186,376	-1,333	185,043 74.00
76.00	03951	WOUND CARE	83,280	75,065	158,345	-40,542	117,803 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	398,982	126,509	525,491	-24,667	500,824 90.00
91.00	09100	EMERGENCY	742,152	473,641	1,215,793	-34,669	1,181,124 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,924,288	21,593,198	36,517,486	89,207	36,606,693 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	422,801	460,627	883,428	-88,935	794,493 192.00
194.00	07950	MARKETING	157,321	44,899	202,220	-272	201,948 194.00
194.01	07951	HOSPICE	0	0	0	0	0 194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0 194.02
194.03	07953	VACANT AREA	0	0	0	0	0 194.03
194.04	07954	LAKEFRONT	0	0	0	0	0 194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	15,504,410	22,098,724	37,603,134	0	37,603,134 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet A

Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	2,243,020	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-344	627,339	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-31,442	1,933,137	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,807,848	7,918,700	5.00
7.00	00700	OPERATION OF PLANT	-144,764	2,266,987	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	101,195	8.00
9.00	00900	HOUSEKEEPING	0	409,650	9.00
10.00	01000	DIETARY	0	603,323	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	304,238	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-431	510,671	14.00
15.00	01500	PHARMACY	0	515,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-146	195,309	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,760,554	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-20,988	727,929	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-87,307	3,359,167	30.00
31.00	03100	INTENSIVE CARE UNIT	-7,618	890,233	31.00
40.00	04000	SUBPROVIDER - IPF	0	415,772	40.00
41.00	04100	SUBPROVIDER - IRF	-614	362,710	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-105,025	2,251,515	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0	161,404	50.01
51.00	05100	RECOVERY ROOM	0	181,993	51.00
53.00	05300	ANESTHESIOLOGY	-479,523	53,036	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	616,383	54.00
54.01	03630	ULTRA SOUND	0	81,343	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-9,160	174,904	55.00
56.00	05600	RADIOISOTOPE	0	170,954	56.00
56.01	03650	VASCULAR LAB	-107,625	58,343	56.01
56.02	03950	STRAUSS ONCOLOGY	-8,205	184,683	56.02
57.00	05700	CT SCAN	0	128,571	57.00
58.00	05800	MRI	0	37,050	58.00
59.00	05900	CARDIAC CATHETERIZATION	-374	200,302	59.00
60.00	06000	LABORATORY	-870	916,368	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	148,495	63.00
65.00	06500	RESPIRATORY THERAPY	0	456,887	65.00
66.00	06600	PHYSICAL THERAPY	-7,307	603,441	66.00
69.00	06900	ELECTROCARDIOLOGY	0	198,853	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16,480	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	209,252	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,619,605	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,802,861	73.00
74.00	07400	RENAL DIALYSIS	0	185,043	74.00
76.00	03951	WOUND CARE	-10,447	107,356	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-40,152	460,672	90.00
91.00	09100	EMERGENCY	-237,054	944,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	508,452	37,115,145	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	794,493	192.00
194.00	07950	MARKETING	0	201,948	194.00
194.01	07951	HOSPICE	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	194.02
194.03	07953	VACANT AREA	0	0	194.03
194.04	07954	LAKEFRONT	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	508,452	38,111,586	200.00

RECLASSIFICATIONS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet A-6

Date/Time Prepared:
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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAPITAL RENTAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,033,395		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	285,782		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	1,319,177		
	B - CAPITAL EQUIPMENT LEASE INTEREST COS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	479		1.00
	TOTALS		0	479		
	C - CAPITAL PROPERTY TAX COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	719,976		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	719,976		
	D - CAPITAL INSURANCE COSTS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,662		1.00
	TOTALS		0	4,662		
	E - CHARGEABLE PHARMACEUTICAL COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,802,861		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	1,802,861		
	F - CHARGEABLE MEDICAL SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	209,252		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00

RECLASSIFICATIONS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet A-6

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
TOTALS			0	209,252		
G - LAUNDRY & LINEN COSTS						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	2,485		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
TOTALS			0	2,485		
H - CHARGEABLE IMPLANT/DEVICE COSTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,619,605		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
TOTALS			0	1,619,605		
I - TRANSCRIPTION COSTS						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,497		1.00
TOTALS			0	4,497		
500.00	Grand Total: Increases		0	5,682,994		500.00

RECLASSIFICATIONS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet A-6
Date/Time Prepared:
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Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - CAPITAL RENTAL COSTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	387	10		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	892,874	10		2.00	
3.00	OPERATION OF PLANT	7.00	0	646	0		3.00	
4.00	HOUSEKEEPING	9.00	0	11,546	0		4.00	
5.00	DIETARY	10.00	0	580	0		5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	25,323	0		6.00	
7.00	PHARMACY	15.00	0	53,815	0		7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	613	0		8.00	
9.00	I&R SERVICES-OTHER PRGM	22.00	0	568	0		9.00	
	COSTS APPRV							
10.00	ADULTS & PEDIATRICS	30.00	0	2,373	0		10.00	
11.00	INTENSIVE CARE UNIT	31.00	0	3,105	0		11.00	
12.00	SUBPROVIDER - IPF	40.00	0	732	0		12.00	
13.00	SUBPROVIDER - IRF	41.00	0	559	0		13.00	
14.00	OPERATING ROOM	50.00	0	84,067	0		14.00	
15.00	ANESTHESIOLOGY	53.00	0	517	0		15.00	
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	50,759	0		16.00	
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	36,140	0		17.00	
18.00	RADIOISOTOPE	56.00	0	72	0		18.00	
19.00	VASCULAR LAB	56.01	0	201	0		19.00	
20.00	STRAUSS ONCOLOGY	56.02	0	49,081	0		20.00	
21.00	CARDIAC CATHETERIZATION	59.00	0	72	0		21.00	
22.00	LABORATORY	60.00	0	113	0		22.00	
23.00	RESPIRATORY THERAPY	65.00	0	60,100	0		23.00	
24.00	PHYSICAL THERAPY	66.00	0	201	0		24.00	
25.00	ELECTROCARDIOLOGY	69.00	0	329	0		25.00	
26.00	WOUND CARE	76.00	0	805	0		26.00	
27.00	CLINIC	90.00	0	1,344	0		27.00	
28.00	EMERGENCY	91.00	0	1,110	0		28.00	
29.00	PHYSICIANS PRIVATE OFFICES	192.00	0	40,873	0		29.00	
30.00	MARKETING	194.00	0	272	0		30.00	
	TOTALS		0	1,319,177				
	B - CAPITAL EQUIPMENT LEASE INTEREST COS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	479	11		1.00	
	TOTALS		0	479				
	C - CAPITAL PROPERTY TAX COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	676,371	13		1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,371	0		2.00	
3.00	PHYSICIANS PRIVATE OFFICES	192.00	0	38,234	0		3.00	
	TOTALS		0	719,976				
	D - CAPITAL INSURANCE COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,662	12		1.00	
	TOTALS		0	4,662				
	E - CHARGEABLE PHARMACEUTICAL COSTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,923	0		1.00	
2.00	DIETARY	10.00	0	4,848	0		2.00	
3.00	PHARMACY	15.00	0	825,302	0		3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	25,919	0		4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	14,932	0		5.00	
6.00	SUBPROVIDER - IPF	40.00	0	3	0		6.00	
7.00	SUBPROVIDER - IRF	41.00	0	76	0		7.00	
8.00	OPERATING ROOM	50.00	0	31,850	0		8.00	
9.00	GASTRO INTESTINAL SERVICES	50.01	0	4,999	0		9.00	
10.00	RECOVERY ROOM	51.00	0	625	0		10.00	
11.00	ANESTHESIOLOGY	53.00	0	8,663	0		11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,982	0		12.00	
13.00	ULTRA SOUND	54.01	0	14	0		13.00	
14.00	RADIOISOTOPE	56.00	0	57	0		14.00	
15.00	STRAUSS ONCOLOGY	56.02	0	829,503	0		15.00	
16.00	CT SCAN	57.00	0	1,451	0		16.00	
17.00	LABORATORY	60.00	0	44	0		17.00	
18.00	RESPIRATORY THERAPY	65.00	0	450	0		18.00	
19.00	ELECTROCARDIOLOGY	69.00	0	195	0		19.00	
20.00	RENAL DIALYSIS	74.00	0	1,333	0		20.00	
21.00	WOUND CARE	76.00	0	2,491	0		21.00	
22.00	CLINIC	90.00	0	17,767	0		22.00	
23.00	EMERGENCY	91.00	0	18,149	0		23.00	
24.00	PHYSICIANS PRIVATE OFFICES	192.00	0	8,285	0		24.00	
	TOTALS		0	1,802,861				
	F - CHARGEABLE MEDICAL SUPPLY COSTS							
1.00	LAUNDRY & LINEN SERVICE	8.00	0	1,431	0		1.00	
2.00	HOUSEKEEPING	9.00	0	2,217	0		2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	20,119	0		3.00	

RECLASSIFICATIONS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet A-6
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
4.00	PHARMACY	15.00	0	903	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	35,981	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	16,105	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	568	0	7.00
8.00	SUBPROVIDER - IRF	41.00	0	1,367	0	8.00
9.00	OPERATING ROOM	50.00	0	76,717	0	9.00
10.00	GASTRO INTESTINAL SERVICES	50.01	0	3,472	0	10.00
11.00	RECOVERY ROOM	51.00	0	9,289	0	11.00
12.00	ANESTHESIOLOGY	53.00	0	2,938	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,141	0	13.00
14.00	ULTRA SOUND	54.01	0	5,316	0	14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	295	0	15.00
16.00	RADIOISOTOPE	56.00	0	59	0	16.00
17.00	STRAUSS ONCOLOGY	56.02	0	723	0	17.00
18.00	CT SCAN	57.00	0	31	0	18.00
19.00	MRI	58.00	0	263	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	897	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	2,691	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	632	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	2,080	0	23.00
24.00	WOUND CARE	76.00	0	524	0	24.00
25.00	CLINIC	90.00	0	1,059	0	25.00
26.00	EMERGENCY	91.00	0	14,891	0	26.00
27.00	PHYSICIANS PRIVATE OFFICES	192.00	0	1,543	0	27.00
	TOTALS		0	209,252		
G - LAUNDRY & LINEN COSTS						
1.00	HOUSEKEEPING	9.00	0	1,296	0	1.00
2.00	SUBPROVIDER - IPF	40.00	0	22	0	2.00
3.00	OPERATING ROOM	50.00	0	232	0	3.00
4.00	WOUND CARE	76.00	0	481	0	4.00
5.00	EMERGENCY	91.00	0	454	0	5.00
	TOTALS		0	2,485		
H - CHARGEABLE IMPLANT/DEVICE COSTS						
1.00	INTENSIVE CARE UNIT	31.00	0	3,822	0	1.00
2.00	OPERATING ROOM	50.00	0	1,466,142	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,790	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	103,545	0	4.00
5.00	WOUND CARE	76.00	0	36,241	0	5.00
6.00	EMERGENCY	91.00	0	65	0	6.00
	TOTALS		0	1,619,605		
I - TRANSCRIPTION COSTS						
1.00	CLINIC	90.00	0	4,497	0	1.00
	TOTALS		0	4,497		
500.00	Grand Total: Decreases		0	5,682,994		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	6,028,062	0	6,028,062	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	6,028,062	0	6,028,062	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	6,028,062	0	6,028,062	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	6,028,062	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	6,028,062	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	6,028,062	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet A-7
Part II
Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	489,649	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	336,760	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	826,409	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	489,649				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	336,760				2.00
3.00	Total (sum of lines 1-2)	0	826,409				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,028,062	0	6,028,062	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	6,028,062	0	6,028,062	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	489,649	1,033,395	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	336,416	285,782	2.00
3.00	Total (sum of lines 1-2)	0	0	0	826,065	1,319,177	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	719,976	0	2,243,020	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	479	4,662	0	0	627,339	2.00
3.00	Total (sum of lines 1-2)	479	4,662	719,976	0	2,870,359	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet A-8

Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)	B	-141,406	OPERATION OF PLANT	7.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,065,662			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-146	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TELEPHONE DIRECT EXPENSE	A	-9,174	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet A-8

Date/Time Prepared:
10/24/2019 1:36 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 PBX SALARY	A	-12,375	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 PBX BENEFITS	A	-2,241	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03 TELEPHONE DEPR'N	A	-201	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.03
33.04 TELEVISION DEPR'N	A	-143	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05 TELEVISION CABLE	A	-2,639	OPERATION OF PLANT	7.00	0	33.05
33.06 OTHER OPERATING REVENUE	B	3,612	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 STUDENT FEES AND PMTS	B	-17,484	I&R SERVICES-OTHER PRGM	22.00	0	33.07
			COSTS APPRV			
33.08 RENTAL INCOME	B	-6,611	CLINIC	90.00	0	33.08
33.09 OTHER OPERATING REVENUE	B	-30	STRAUSS ONCOLOGY	56.02	0	33.09
33.10 PURCHASED SERVICES	A	-2,970	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11 PURCHASED SERVICES	A	-38,511	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 PURCHASED SERVICES	A	-26,231	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13 PURCHASED SERVICES	A	-112	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 PURCHASED SERVICES	A	-719	OPERATION OF PLANT	7.00	0	33.14
33.15 TRAVEL	A	-112	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16 SENIOR SERVICES	A	-30,984	ADULTS & PEDIATRICS	30.00	0	33.16
33.17 DONATIONS	A	-115,858	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18 DUES & SUBSCRIPTIONS	A	-3,895	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19 DUES & SUBSCRIPTIONS	A	-3,504	I&R SERVICES-OTHER PRGM	22.00	0	33.19
			COSTS APPRV			
33.20 LOBBYING	A	-13,351	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21 PENALTIES	A	-1,436	OPERATING ROOM	50.00	0	33.21
33.22 PENALTIES	A	-169	CENTRAL SERVICES & SUPPLY	14.00	0	33.22
33.23 LEGAL	A	-3,940	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24 SALES TAX	A	-262	CENTRAL SERVICES & SUPPLY	14.00	0	33.24
33.25 PROVIDER ASSESSMENT FEE	A	2,005,006	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.26
(3)						
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		508,452				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet A-8-2

Date/Time Prepared:
10/24/2019 1:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	3,442	3,442	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	56,323	56,323	0	211,500	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	7,618	7,618	0	211,500	0	3.00
4.00	41.00	SUBPROVIDER - IRF	614	614	0	211,500	0	4.00
5.00	50.00	OPERATING ROOM	103,589	103,589	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	479,523	479,523	0	239,400	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	9,160	9,160	0	271,900	0	7.00
8.00	56.01	VASCULAR LAB	107,625	107,625	0	271,900	0	8.00
9.00	56.02	STRAUSS ONCOLOGY	8,175	8,175	0	271,900	0	9.00
10.00	59.00	CARDIAC CATHETERIZATION	374	374	0	211,500	0	10.00
11.00	60.00	LABORATORY	870	870	0	260,300	0	11.00
12.00	66.00	PHYSICAL THERAPY	7,307	7,307	0	211,500	0	12.00
13.00	76.00	WOUND CARE	10,447	10,447	0	211,500	0	13.00
14.00	90.00	CLINIC	33,541	33,541	0	211,500	0	14.00
15.00	91.00	EMERGENCY	237,054	237,054	0	211,500	0	15.00
200.00			1,065,662	1,065,662	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	7.00
8.00	56.01	VASCULAR LAB	0	0	0	0	0	8.00
9.00	56.02	STRAUSS ONCOLOGY	0	0	0	0	0	9.00
10.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	10.00
11.00	60.00	LABORATORY	0	0	0	0	0	11.00
12.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	12.00
13.00	76.00	WOUND CARE	0	0	0	0	0	13.00
14.00	90.00	CLINIC	0	0	0	0	0	14.00
15.00	91.00	EMERGENCY	0	0	0	0	0	15.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	3,442		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	56,323		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	7,618		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	614		4.00
5.00	50.00	OPERATING ROOM	0	0	0	103,589		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	479,523		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	9,160		7.00
8.00	56.01	VASCULAR LAB	0	0	0	107,625		8.00
9.00	56.02	STRAUSS ONCOLOGY	0	0	0	8,175		9.00
10.00	59.00	CARDIAC CATHETERIZATION	0	0	0	374		10.00
11.00	60.00	LABORATORY	0	0	0	870		11.00
12.00	66.00	PHYSICAL THERAPY	0	0	0	7,307		12.00
13.00	76.00	WOUND CARE	0	0	0	10,447		13.00
14.00	90.00	CLINIC	0	0	0	33,541		14.00
15.00	91.00	EMERGENCY	0	0	0	237,054		15.00
200.00			0	0	0	1,065,662		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet B
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,243,020	2,243,020				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	627,339		627,339			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,933,137	18,161	5,201	1,956,499		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,918,700	249,196	71,367	187,581	8,426,844	5.00
7.00	00700	OPERATION OF PLANT	2,266,987	309,910	88,755	58,882	2,724,534	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,195	18,097	5,183	0	124,475	8.00
9.00	00900	HOUSEKEEPING	409,650	19,471	5,576	38,213	472,910	9.00
10.00	01000	DIETARY	603,323	41,165	11,789	37,422	693,699	10.00
11.00	01100	CAFETERIA	0	20,724	5,935	0	26,659	11.00
13.00	01300	NURSING ADMINISTRATION	304,238	2,248	644	35,057	342,187	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	510,671	21,707	6,217	13,758	552,353	14.00
15.00	01500	PHARMACY	515,347	7,805	2,235	54,474	579,861	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,309	17,075	4,890	16,600	233,874	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,760,554	0	0	217,306	1,977,860	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	727,929	65,108	18,646	0	811,683	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,359,167	357,590	102,410	370,564	4,189,731	30.00
31.00	03100	INTENSIVE CARE UNIT	890,233	75,451	21,608	96,830	1,084,122	31.00
40.00	04000	SUBPROVIDER - IPF	415,772	32,544	9,320	48,882	506,518	40.00
41.00	04100	SUBPROVIDER - IRF	362,710	63,059	18,059	42,518	486,346	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,251,515	177,465	50,824	133,355	2,613,159	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	161,404	23,043	6,599	13,787	204,833	50.01
51.00	05100	RECOVERY ROOM	181,993	21,585	6,182	16,897	226,657	51.00
53.00	05300	ANESTHESIOLOGY	53,036	2,538	727	4,463	60,764	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	616,383	76,170	21,814	59,288	773,655	54.00
54.01	03630	ULTRA SOUND	81,343	1,099	315	9,119	91,876	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	174,904	23,647	6,772	12,347	217,670	55.00
56.00	05600	RADIOISOTOPE	170,954	19,124	5,477	8,106	203,661	56.00
56.01	03650	VASCULAR LAB	58,343	0	0	6,731	65,074	56.01
56.02	03950	STRAUSS ONCOLOGY	184,683	0	0	18,267	202,950	56.02
57.00	05700	CT SCAN	128,571	5,775	1,654	13,270	149,270	57.00
58.00	05800	MRI	37,050	6,591	1,888	4,560	50,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	200,302	9,867	2,826	18,331	231,326	59.00
60.00	06000	LABORATORY	916,368	29,435	8,430	49,905	1,004,138	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	148,495	1,407	403	0	150,305	63.00
65.00	06500	RESPIRATORY THERAPY	456,887	6,707	1,921	46,935	512,450	65.00
66.00	06600	PHYSICAL THERAPY	603,441	23,005	6,588	71,096	704,130	66.00
69.00	06900	ELECTROCARDIOLOGY	198,853	46,099	13,202	21,817	279,971	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,480	642	184	1,994	19,300	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	209,252	0	0	0	209,252	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,619,605	0	0	0	1,619,605	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,802,861	0	0	0	1,802,861	73.00
74.00	07400	RENAL DIALYSIS	185,043	0	0	0	185,043	74.00
76.00	03951	WOUND CARE	107,356	17,049	4,883	10,529	139,817	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	460,672	43,915	12,577	50,442	567,606	90.00
91.00	09100	EMERGENCY	944,070	76,132	21,803	93,829	1,135,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,115,145	1,930,606	552,904	1,883,155	36,654,952	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	794,493	232,525	66,593	53,454	1,147,065	192.00
194.00	07950	MARKETING	201,948	1,991	570	19,890	224,399	194.00
194.01	07951	HOSPICE	0	13,452	3,852	0	17,304	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	VACANT AREA	0	52,504	0	0	52,504	194.03
194.04	07954	LAKEFRONT	0	11,942	3,420	0	15,362	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,111,586	2,243,020	627,339	1,956,499	38,111,586	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet B
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,426,844					5.00
7.00	00700	OPERATION OF PLANT	773,435	3,497,969				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,336	38,002	197,813			8.00
9.00	00900	HOUSEKEEPING	134,249	40,888	0	648,047		9.00
10.00	01000	DIETARY	196,926	86,445	0	16,385	993,455	10.00
11.00	01100	CAFETERIA	7,568	43,519	0	8,249	481,169	11.00
13.00	01300	NURSING ADMINISTRATION	97,139	4,722	0	895	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	156,801	45,583	0	8,640	0	14.00
15.00	01500	PHARMACY	164,610	16,390	0	3,107	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,392	35,857	0	6,796	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	561,471	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	230,419	136,722	0	25,914	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,189,369	750,910	77,497	142,327	240,633	30.00
31.00	03100	INTENSIVE CARE UNIT	307,758	158,441	25,316	30,031	33,726	31.00
40.00	04000	SUBPROVIDER - IPF	143,789	68,341	5,672	12,953	32,381	40.00
41.00	04100	SUBPROVIDER - IRF	138,063	132,419	16,940	25,098	23,275	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	741,818	372,664	21,417	70,634	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	58,148	48,389	3,041	9,172	0	50.01
51.00	05100	RECOVERY ROOM	64,343	45,327	0	8,591	0	51.00
53.00	05300	ANESTHESIOLOGY	17,250	5,329	0	1,010	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	219,624	159,952	15,261	30,317	0	54.00
54.01	03630	ULTRA SOUND	26,082	2,307	0	437	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	61,792	49,657	1,530	9,412	0	55.00
56.00	05600	RADIOISOTOPE	57,815	40,160	1,531	7,612	0	56.00
56.01	03650	VASCULAR LAB	18,473	0	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY	57,613	0	1,530	0	0	56.02
57.00	05700	CT SCAN	42,374	12,128	0	2,299	0	57.00
58.00	05800	MRI	14,219	13,841	0	2,623	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	65,668	20,721	0	3,927	0	59.00
60.00	06000	LABORATORY	285,053	61,812	0	11,716	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	42,668	2,954	0	560	0	63.00
65.00	06500	RESPIRATORY THERAPY	145,473	14,084	0	2,669	0	65.00
66.00	06600	PHYSICAL THERAPY	199,887	48,308	0	9,156	0	66.00
69.00	06900	ELECTROCARDIOLOGY	79,478	96,805	1,530	18,348	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,479	1,349	1,530	256	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,402	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	459,770	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	511,793	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	52,530	0	0	0	0	74.00
76.00	03951	WOUND CARE	39,691	35,803	0	6,786	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	161,131	92,218	3,097	17,479	0	90.00
91.00	09100	EMERGENCY	322,438	159,871	9,925	30,302	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,013,337	2,841,918	185,817	523,701	811,184	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	325,627	488,288	747	92,549	164,246	192.00
194.00	07950	MARKETING	63,702	4,182	0	793	0	194.00
194.01	07951	HOSPICE	4,912	28,248	11,249	5,354	16,566	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	1,459	194.02
194.03	07953	VACANT AREA	14,905	110,255	0	20,897	0	194.03
194.04	07954	LAKEFRONT	4,361	25,078	0	4,753	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,426,844	3,497,969	197,813	648,047	993,455	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0082

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	567,164					11.00
13.00	01300	NURSING ADMINISTRATION	10,228	455,171				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,736	0	771,113			14.00
15.00	01500	PHARMACY	15,841	20,677	0	800,486		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,634	0	0	0	355,553	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	88,369	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	136,239	177,839	0	0	27,975	30.00
31.00	03100	INTENSIVE CARE UNIT	30,619	39,981	0	0	6,380	31.00
40.00	04000	SUBPROVIDER - IPF	26,025	33,964	0	0	2,058	40.00
41.00	04100	SUBPROVIDER - IRF	12,720	16,612	0	0	1,674	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	41,801	54,573	0	0	49,409	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	3,294	4,288	0	0	6,370	50.01
51.00	05100	RECOVERY ROOM	6,068	7,913	0	0	8,393	51.00
53.00	05300	ANESTHESIOLOGY	477	0	0	0	7,526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,927	0	0	0	10,381	54.00
54.01	03630	ULTRA SOUND	1,734	0	0	0	2,292	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,207	0	0	0	3,911	55.00
56.00	05600	RADIOISOTOPE	2,254	0	0	0	3,877	56.00
56.01	03650	VASCULAR LAB	2,080	0	0	0	2,428	56.01
56.02	03950	STRAUSS ONCOLOGY	5,699	0	0	0	1,306	56.02
57.00	05700	CT SCAN	5,743	0	0	0	26,620	57.00
58.00	05800	MRI	1,430	0	0	0	3,389	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,727	0	0	0	11,042	59.00
60.00	06000	LABORATORY	24,400	0	0	0	42,671	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	3,260	63.00
65.00	06500	RESPIRATORY THERAPY	18,896	24,671	0	0	4,687	65.00
66.00	06600	PHYSICAL THERAPY	23,403	30,536	0	0	11,655	66.00
69.00	06900	ELECTROCARDIOLOGY	7,498	0	0	0	10,636	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	975	0	0	0	221	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	88,228	0	15,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	682,885	0	12,790	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	800,486	46,363	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	660	74.00
76.00	03951	WOUND CARE	2,925	0	0	0	1,097	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,755	0	0	0	1,629	90.00
91.00	09100	EMERGENCY	33,805	44,117	0	0	28,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	554,509	455,171	771,113	800,486	354,995	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	7,671	0	0	0	558	192.00
194.00	07950	MARKETING	4,724	0	0	0	0	194.00
194.01	07951	HOSPICE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	260	0	0	0	0	194.02
194.03	07953	VACANT AREA	0	0	0	0	0	194.03
194.04	07954	LAKEFRONT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	567,164	455,171	771,113	800,486	355,553	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0082

Period:
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Cost Center Description			INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,539,331					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		1,293,107				22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,723,868	877,848	9,534,236	-2,601,716	6,932,520	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,716,374	0	1,716,374	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	831,701	0	831,701	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	853,147	0	853,147	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	691,411	352,088	5,008,974	-1,043,499	3,965,475	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0	0	337,535	0	337,535	50.01
51.00	05100	RECOVERY ROOM	0	0	367,292	0	367,292	51.00
53.00	05300	ANESTHESIOLOGY	0	0	92,356	0	92,356	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,232,117	0	1,232,117	54.00
54.01	03630	ULTRA SOUND	0	0	124,728	0	124,728	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	347,179	0	347,179	55.00
56.00	05600	RADIOISOTOPE	0	0	316,910	0	316,910	56.00
56.01	03650	VASCULAR LAB	0	0	88,055	0	88,055	56.01
56.02	03950	STRAUSS ONCOLOGY	0	0	269,098	0	269,098	56.02
57.00	05700	CT SCAN	0	0	238,434	0	238,434	57.00
58.00	05800	MRI	0	0	85,591	0	85,591	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	336,411	0	336,411	59.00
60.00	06000	LABORATORY	0	0	1,429,790	0	1,429,790	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	199,747	0	199,747	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	722,930	0	722,930	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,027,075	0	1,027,075	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	494,266	0	494,266	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	29,110	0	29,110	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	372,187	0	372,187	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,775,050	0	2,775,050	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,161,503	0	3,161,503	73.00
74.00	07400	RENAL DIALYSIS	0	0	238,233	0	238,233	74.00
76.00	03951	WOUND CARE	0	0	226,119	0	226,119	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	844,915	0	844,915	90.00
91.00	09100	EMERGENCY	124,052	63,171	1,952,505	-187,223	1,765,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,539,331	1,293,107	35,253,568	-3,832,438	31,421,130	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	2,226,751	0	2,226,751	192.00
194.00	07950	MARKETING	0	0	297,800	0	297,800	194.00
194.01	07951	HOSPICE	0	0	83,633	0	83,633	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	1,719	0	1,719	194.02
194.03	07953	VACANT AREA	0	0	198,561	0	198,561	194.03
194.04	07954	LAKEFRONT	0	0	49,554	0	49,554	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,539,331	1,293,107	38,111,586	-3,832,438	34,279,148	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0082

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	18,161	5,201	23,362	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	249,196	71,367	320,563	5.00
7.00	00700	OPERATION OF PLANT	0	309,910	88,755	398,665	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,097	5,183	23,280	8.00
9.00	00900	HOUSEKEEPING	0	19,471	5,576	25,047	9.00
10.00	01000	DIETARY	0	41,165	11,789	52,954	10.00
11.00	01100	CAFETERIA	0	20,724	5,935	26,659	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,248	644	2,892	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,707	6,217	27,924	14.00
15.00	01500	PHARMACY	0	7,805	2,235	10,040	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,075	4,890	21,965	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	65,108	18,646	83,754	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	357,590	102,410	460,000	30.00
31.00	03100	INTENSIVE CARE UNIT	0	75,451	21,608	97,059	31.00
40.00	04000	SUBPROVIDER - IPF	0	32,544	9,320	41,864	40.00
41.00	04100	SUBPROVIDER - IRF	0	63,059	18,059	81,118	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	177,465	50,824	228,289	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0	23,043	6,599	29,642	50.01
51.00	05100	RECOVERY ROOM	0	21,585	6,182	27,767	51.00
53.00	05300	ANESTHESIOLOGY	0	2,538	727	3,265	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	76,170	21,814	97,984	54.00
54.01	03630	ULTRA SOUND	0	1,099	315	1,414	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	23,647	6,772	30,419	55.00
56.00	05600	RADIOISOTOPE	0	19,124	5,477	24,601	56.00
56.01	03650	VASCULAR LAB	0	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY	0	0	0	0	56.02
57.00	05700	CT SCAN	0	5,775	1,654	7,429	57.00
58.00	05800	MRI	0	6,591	1,888	8,479	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,867	2,826	12,693	59.00
60.00	06000	LABORATORY	0	29,435	8,430	37,865	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	1,407	403	1,810	63.00
65.00	06500	RESPIRATORY THERAPY	0	6,707	1,921	8,628	65.00
66.00	06600	PHYSICAL THERAPY	0	23,005	6,588	29,593	66.00
69.00	06900	ELECTROCARDIOLOGY	0	46,099	13,202	59,301	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	642	184	826	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03951	WOUND CARE	0	17,049	4,883	21,932	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	43,915	12,577	56,492	90.00
91.00	09100	EMERGENCY	0	76,132	21,803	97,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,930,606	552,904	2,483,510	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	232,525	66,593	299,118	192.00
194.00	07950	MARKETING	0	1,991	570	2,561	194.00
194.01	07951	HOSPICE	0	13,452	3,852	17,304	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	VACANT AREA	0	52,504	0	52,504	194.03
194.04	07954	LAKEFRONT	0	11,942	3,420	15,362	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,243,020	627,339	2,870,359	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	322,803					5.00
7.00	00700	OPERATION OF PLANT	29,627	428,995				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,354	4,661	29,295			8.00
9.00	00900	HOUSEKEEPING	5,142	5,015	0	35,660		9.00
10.00	01000	DIETARY	7,543	10,602	0	902	72,448	10.00
11.00	01100	CAFETERIA	290	5,337	0	454	35,090	11.00
13.00	01300	NURSING ADMINISTRATION	3,721	579	0	49	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,006	5,590	0	475	0	14.00
15.00	01500	PHARMACY	6,305	2,010	0	171	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,543	4,398	0	374	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21,507	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	8,826	16,768	0	1,426	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	45,572	92,093	11,474	7,830	17,548	30.00
31.00	03100	INTENSIVE CARE UNIT	11,789	19,431	3,749	1,652	2,460	31.00
40.00	04000	SUBPROVIDER - IPF	5,508	8,381	840	713	2,361	40.00
41.00	04100	SUBPROVIDER - IRF	5,289	16,240	2,509	1,381	1,697	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,415	45,704	3,172	3,887	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	2,227	5,934	450	505	0	50.01
51.00	05100	RECOVERY ROOM	2,465	5,559	0	473	0	51.00
53.00	05300	ANESTHESIOLOGY	661	654	0	56	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,413	19,617	2,260	1,668	0	54.00
54.01	03630	ULTRA SOUND	999	283	0	24	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,367	6,090	227	518	0	55.00
56.00	05600	RADIOISOTOPE	2,215	4,925	227	419	0	56.00
56.01	03650	VASCULAR LAB	708	0	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY	2,207	0	227	0	0	56.02
57.00	05700	CT SCAN	1,623	1,487	0	126	0	57.00
58.00	05800	MRI	545	1,697	0	144	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,515	2,541	0	216	0	59.00
60.00	06000	LABORATORY	10,919	7,581	0	645	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	1,634	362	0	31	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,572	1,727	0	147	0	65.00
66.00	06600	PHYSICAL THERAPY	7,657	5,925	0	504	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,044	11,872	227	1,010	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	210	165	227	14	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,275	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,612	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,604	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,012	0	0	0	0	74.00
76.00	03951	WOUND CARE	1,520	4,391	0	373	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,172	11,310	459	962	0	90.00
91.00	09100	EMERGENCY	12,351	19,607	1,470	1,667	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	306,964	348,536	27,518	28,816	59,156	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	12,473	59,884	111	5,093	11,978	192.00
194.00	07950	MARKETING	2,440	513	0	44	0	194.00
194.01	07951	HOSPICE	188	3,464	1,666	295	1,208	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	106	194.02
194.03	07953	VACANT AREA	571	13,522	0	1,150	0	194.03
194.04	07954	LAKEFRONT	167	3,076	0	262	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	322,803	428,995	29,295	35,660	72,448	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0082

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	67,830					11.00
13.00	01300	NURSING ADMINISTRATION	1,223	8,883				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	925	0	41,084			14.00
15.00	01500	PHARMACY	1,894	404	0	21,475		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,511	0	0	0	30,989	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	10,569	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,291	3,471	0	0	2,444	30.00
31.00	03100	INTENSIVE CARE UNIT	3,662	780	0	0	557	31.00
40.00	04000	SUBPROVIDER - IPF	3,113	663	0	0	180	40.00
41.00	04100	SUBPROVIDER - IRF	1,521	324	0	0	146	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,999	1,065	0	0	4,245	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	394	84	0	0	556	50.01
51.00	05100	RECOVERY ROOM	726	154	0	0	733	51.00
53.00	05300	ANESTHESIOLOGY	57	0	0	0	657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,742	0	0	0	907	54.00
54.01	03630	ULTRA SOUND	207	0	0	0	200	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	384	0	0	0	342	55.00
56.00	05600	RADIOISOTOPE	270	0	0	0	339	56.00
56.01	03650	VASCULAR LAB	249	0	0	0	212	56.01
56.02	03950	STRAUSS ONCOLOGY	682	0	0	0	114	56.02
57.00	05700	CT SCAN	687	0	0	0	2,326	57.00
58.00	05800	MRI	171	0	0	0	296	58.00
59.00	05900	CARDIAC CATHETERIZATION	446	0	0	0	965	59.00
60.00	06000	LABORATORY	2,918	0	0	0	3,728	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	285	63.00
65.00	06500	RESPIRATORY THERAPY	2,260	481	0	0	409	65.00
66.00	06600	PHYSICAL THERAPY	2,799	596	0	0	1,018	66.00
69.00	06900	ELECTROCARDIOLOGY	897	0	0	0	929	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	117	0	0	0	19	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,701	0	1,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	36,383	0	1,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,475	4,050	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	58	74.00
76.00	03951	WOUND CARE	350	0	0	0	96	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	210	0	0	0	142	90.00
91.00	09100	EMERGENCY	4,043	861	0	0	2,533	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,317	8,883	41,084	21,475	30,940	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	917	0	0	0	49	192.00
194.00	07950	MARKETING	565	0	0	0	0	194.00
194.01	07951	HOSPICE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	31	0	0	0	0	194.02
194.03	07953	VACANT AREA	0	0	0	0	0	194.03
194.04	07954	LAKEFRONT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,830	8,883	41,084	21,475	30,989	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	24,102					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		121,343				22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			661,145	0	661,145	30.00
31.00	03100	INTENSIVE CARE UNIT			142,295	0	142,295	31.00
40.00	04000	SUBPROVIDER - IPF			64,207	0	64,207	40.00
41.00	04100	SUBPROVIDER - IRF			110,733	0	110,733	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			321,369	0	321,369	50.00
50.01	03340	GASTRO INTESTINAL SERVICES			39,957	0	39,957	50.01
51.00	05100	RECOVERY ROOM			38,079	0	38,079	51.00
53.00	05300	ANESTHESIOLOGY			5,403	0	5,403	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			134,299	0	134,299	54.00
54.01	03630	ULTRA SOUND			3,236	0	3,236	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC			40,494	0	40,494	55.00
56.00	05600	RADIOISOTOPE			33,093	0	33,093	56.00
56.01	03650	VASCULAR LAB			1,249	0	1,249	56.01
56.02	03950	STRAUSS ONCOLOGY			3,448	0	3,448	56.02
57.00	05700	CT SCAN			13,836	0	13,836	57.00
58.00	05800	MRI			11,386	0	11,386	58.00
59.00	05900	CARDIAC CATHETERIZATION			19,595	0	19,595	59.00
60.00	06000	LABORATORY			64,252	0	64,252	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.			4,122	0	4,122	63.00
65.00	06500	RESPIRATORY THERAPY			19,785	0	19,785	65.00
66.00	06600	PHYSICAL THERAPY			48,941	0	48,941	66.00
69.00	06900	ELECTROCARDIOLOGY			77,541	0	77,541	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			1,602	0	1,602	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			8,313	0	8,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			55,112	0	55,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			45,129	0	45,129	73.00
74.00	07400	RENAL DIALYSIS			2,070	0	2,070	74.00
76.00	03951	WOUND CARE			28,788	0	28,788	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC			76,349	0	76,349	90.00
91.00	09100	EMERGENCY			141,588	0	141,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	2,217,416	0	2,217,416	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES			390,261	0	390,261	192.00
194.00	07950	MARKETING			6,361	0	6,361	194.00
194.01	07951	HOSPICE			24,125	0	24,125	194.01
194.02	07952	OTHER NON-REIMBURSABLE			137	0	137	194.02
194.03	07953	VACANT AREA			67,747	0	67,747	194.03
194.04	07954	LAKEFRONT			18,867	0	18,867	194.04
200.00		Cross Foot Adjustments	24,102	121,343	145,445	0	145,445	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,102	121,343	2,870,359	0	2,870,359	202.00

COST ALLOCATION - STATISTICAL BASIS

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Period:
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To 05/31/2019

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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	349,159				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		340,986			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,827	2,827	15,475,217		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,791	38,791	1,483,702	-8,426,844	5.00
7.00	00700	OPERATION OF PLANT	48,242	48,242	465,732	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,817	2,817	0	0	8.00
9.00	00900	HOUSEKEEPING	3,031	3,031	302,255	0	9.00
10.00	01000	DIETARY	6,408	6,408	295,994	0	10.00
11.00	01100	CAFETERIA	3,226	3,226	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	350	350	277,288	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,379	3,379	108,823	0	14.00
15.00	01500	PHARMACY	1,215	1,215	430,867	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,658	2,658	131,297	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,718,816	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	10,135	10,135	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,664	55,664	2,931,061	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,745	11,745	765,894	0	31.00
40.00	04000	SUBPROVIDER - IPF	5,066	5,066	386,637	0	40.00
41.00	04100	SUBPROVIDER - IRF	9,816	9,816	336,299	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,625	27,625	1,054,787	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	3,587	3,587	109,050	0	50.01
51.00	05100	RECOVERY ROOM	3,360	3,360	133,648	0	51.00
53.00	05300	ANESTHESIOLOGY	395	395	35,301	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,857	11,857	468,946	0	54.00
54.01	03630	ULTRA SOUND	171	171	72,128	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,681	3,681	97,657	0	55.00
56.00	05600	RADIOISOTOPE	2,977	2,977	64,112	0	56.00
56.01	03650	VASCULAR LAB	0	0	53,237	0	56.01
56.02	03950	STRAUSS ONCOLOGY	0	0	144,483	0	56.02
57.00	05700	CT SCAN	899	899	104,962	0	57.00
58.00	05800	MRI	1,026	1,026	36,070	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,536	1,536	144,994	0	59.00
60.00	06000	LABORATORY	4,582	4,582	394,730	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	219	219	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,044	1,044	371,239	0	65.00
66.00	06600	PHYSICAL THERAPY	3,581	3,581	562,340	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,176	7,176	172,563	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100	100	15,769	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03951	WOUND CARE	2,654	2,654	83,280	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,836	6,836	398,982	0	90.00
91.00	09100	EMERGENCY	11,851	11,851	742,152	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	300,527	300,527	14,895,095	-8,426,844	28,228,108
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	36,196	36,196	422,801	0	192.00
194.00	07950	MARKETING	310	310	157,321	0	194.00
194.01	07951	HOSPICE	2,094	2,094	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	VACANT AREA	8,173	0	0	0	194.03
194.04	07954	LAKEFRONT	1,859	1,859	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,243,020	627,339	1,956,499	8,426,844	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.424065	1.839779	0.126428	0.283878	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,362	322,803	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001510	0.010874	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

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Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0082

Period:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	259,299				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,817	249,817			8.00
9.00	00900	HOUSEKEEPING	3,031	0	253,451		9.00
10.00	01000	DIETARY	6,408	0	6,408	121,861	10.00
11.00	01100	CAFETERIA	3,226	0	3,226	59,022	26,173
13.00	01300	NURSING ADMINISTRATION	350	0	350	0	472
14.00	01400	CENTRAL SERVICES & SUPPLY	3,379	0	3,379	0	357
15.00	01500	PHARMACY	1,215	0	1,215	0	731
16.00	01600	MEDICAL RECORDS & LIBRARY	2,658	0	2,658	0	583
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	10,135	0	10,135	0	4,078
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,664	97,872	55,664	29,517	6,287
31.00	03100	INTENSIVE CARE UNIT	11,745	31,972	11,745	4,137	1,413
40.00	04000	SUBPROVIDER - IPF	5,066	7,163	5,066	3,972	1,201
41.00	04100	SUBPROVIDER - IRF	9,816	21,393	9,816	2,855	587
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,625	27,048	27,625	0	1,929
50.01	03340	GASTRO INTESTINAL SERVICES	3,587	3,840	3,587	0	152
51.00	05100	RECOVERY ROOM	3,360	0	3,360	0	280
53.00	05300	ANESTHESIOLOGY	395	0	395	0	22
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,857	19,273	11,857	0	1,058
54.01	03630	ULTRA SOUND	171	0	171	0	80
55.00	05500	RADIOLOGY-THERAPEUTIC	3,681	1,932	3,681	0	148
56.00	05600	RADIOISOTOPE	2,977	1,934	2,977	0	104
56.01	03650	VASCULAR LAB	0	0	0	0	96
56.02	03950	STRAUSS ONCOLOGY	0	1,932	0	0	263
57.00	05700	CT SCAN	899	0	899	0	265
58.00	05800	MRI	1,026	0	1,026	0	66
59.00	05900	CARDIAC CATHETERIZATION	1,536	0	1,536	0	172
60.00	06000	LABORATORY	4,582	0	4,582	0	1,126
63.00	06300	BLOOD STORING PROCESSING & TRANS.	219	0	219	0	0
65.00	06500	RESPIRATORY THERAPY	1,044	0	1,044	0	872
66.00	06600	PHYSICAL THERAPY	3,581	0	3,581	0	1,080
69.00	06900	ELECTROCARDIOLOGY	7,176	1,932	7,176	0	346
70.00	07000	ELECTROENCEPHALOGRAPHY	100	1,932	100	0	45
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03951	WOUND CARE	2,654	0	2,654	0	135
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,836	3,911	6,836	0	81
91.00	09100	EMERGENCY	11,851	12,534	11,851	0	1,560
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	210,667	234,668	204,819	99,503	25,589
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	36,196	943	36,196	20,147	354
194.00	07950	MARKETING	310	0	310	0	218
194.01	07951	HOSPICE	2,094	14,206	2,094	2,032	0
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	179	12
194.03	07953	VACANT AREA	8,173	0	8,173	0	0
194.04	07954	LAKEFRONT	1,859	0	1,859	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	3,497,969	197,813	648,047	993,455	567,164
203.00		Unit cost multiplier (Wkst. B, Part I)	13.490098	0.791832	2.556893	8.152362	21.669812
204.00		Cost to be allocated (per Wkst. B, Part II)	428,995	29,295	35,660	72,448	67,830
205.00		Unit cost multiplier (Wkst. B, Part II)	1.654441	0.117266	0.140698	0.594513	2.591602
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	147,136					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,828,857				14.00
15.00	01500	PHARMACY	6,684	0	1,802,861			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	207,082,385		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	58,032	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	57,487	0	0	16,293,084	39,396	30.00
31.00	03100	INTENSIVE CARE UNIT	12,924	0	0	3,716,000	0	31.00
40.00	04000	SUBPROVIDER - IPF	10,979	0	0	1,198,400	0	40.00
41.00	04100	SUBPROVIDER - IRF	5,370	0	0	975,000	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,641	0	0	28,778,978	15,801	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	1,386	0	0	3,709,968	0	50.01
51.00	05100	RECOVERY ROOM	2,558	0	0	4,888,233	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,383,213	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,046,255	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	1,334,616	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,278,055	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,258,090	0	56.00
56.01	03650	VASCULAR LAB	0	0	0	1,414,300	0	56.01
56.02	03950	STRAUSS ONCOLOGY	0	0	0	760,672	0	56.02
57.00	05700	CT SCAN	0	0	0	15,503,863	0	57.00
58.00	05800	MRI	0	0	0	1,973,888	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	6,431,102	0	59.00
60.00	06000	LABORATORY	0	0	0	24,852,333	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	1,898,704	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,975	0	0	2,729,846	0	65.00
66.00	06600	PHYSICAL THERAPY	9,871	0	0	6,787,725	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,194,494	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	128,983	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	209,252	0	8,913,682	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,619,605	0	7,449,087	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,802,861	27,002,204	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	384,497	0	74.00
76.00	03951	WOUND CARE	0	0	0	639,141	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	948,646	0	90.00
91.00	09100	EMERGENCY	14,261	0	0	16,884,144	2,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,136	1,828,857	1,802,861	206,757,203	58,032	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	325,182	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	HOSPICE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	VACANT AREA	0	0	0	0	0	194.03
194.04	07954	LAKEFRONT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	455,171	771,113	800,486	355,553	2,539,331	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.093539	0.421637	0.444009	0.001717	43.757427	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,883	41,084	21,475	30,989	24,102	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.060373	0.022464	0.011912	0.000150	0.415323	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description			INTERNS & RESIDENTS		
			SERVICES-OTHER		
			PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	58,032		22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	39,396		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	15,801		50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0		50.01
51.00	05100	RECOVERY ROOM	0		51.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
54.01	03630	ULTRA SOUND	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		55.00
56.00	05600	RADIOISOTOPE	0		56.00
56.01	03650	VASCULAR LAB	0		56.01
56.02	03950	STRAUSS ONCOLOGY	0		56.02
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0		63.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03951	WOUND CARE	0		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	2,835		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,032		118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	HOSPICE	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0		194.02
194.03	07953	VACANT AREA	0		194.03
194.04	07954	LAKEFRONT	0		194.04
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,293,107		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.282654		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	121,343		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.090967		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS		
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital		PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,932,520		6,932,520	0	6,932,520	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,716,374		1,716,374	0	1,716,374	31.00	
40.00	04000	SUBPROVIDER - IPF	831,701		831,701	0	831,701	40.00	
41.00	04100	SUBPROVIDER - IRF	853,147		853,147	0	853,147	41.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,965,475		3,965,475	0	3,965,475	50.00	
50.01	03340	GASTRO INTESTINAL SERVICES	337,535		337,535	0	337,535	50.01	
51.00	05100	RECOVERY ROOM	367,292		367,292	0	367,292	51.00	
53.00	05300	ANESTHESIOLOGY	92,356		92,356	0	92,356	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,232,117		1,232,117	0	1,232,117	54.00	
54.01	03630	ULTRA SOUND	124,728		124,728	0	124,728	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	347,179		347,179	0	347,179	55.00	
56.00	05600	RADIOISOTOPE	316,910		316,910	0	316,910	56.00	
56.01	03650	VASCULAR LAB	88,055		88,055	0	88,055	56.01	
56.02	03950	STRAUSS ONCOLOGY	269,098		269,098	0	269,098	56.02	
57.00	05700	CT SCAN	238,434		238,434	0	238,434	57.00	
58.00	05800	MRI	85,591		85,591	0	85,591	58.00	
59.00	05900	CARDIAC CATHETERIZATION	336,411		336,411	0	336,411	59.00	
60.00	06000	LABORATORY	1,429,790		1,429,790	0	1,429,790	60.00	
63.00	06300	BLOOD STORING PROCESSING & TRANS.	199,747		199,747	0	199,747	63.00	
65.00	06500	RESPIRATORY THERAPY	722,930	0	722,930	0	722,930	65.00	
66.00	06600	PHYSICAL THERAPY	1,027,075	0	1,027,075	0	1,027,075	66.00	
69.00	06900	ELECTROCARDIOLOGY	494,266		494,266	0	494,266	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	29,110		29,110	0	29,110	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	372,187		372,187	0	372,187	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,775,050		2,775,050	0	2,775,050	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,161,503		3,161,503	0	3,161,503	73.00	
74.00	07400	RENAL DIALYSIS	238,233		238,233	0	238,233	74.00	
76.00	03951	WOUND CARE	226,119		226,119	0	226,119	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	844,915		844,915	0	844,915	90.00	
91.00	09100	EMERGENCY	1,765,282		1,765,282	0	1,765,282	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	716,235		716,235	0	716,235	92.00	
200.00		Subtotal (see instructions)	32,137,365	0	32,137,365	0	32,137,365	200.00	
201.00		Less Observation Beds	716,235		716,235	0	716,235	201.00	
202.00		Total (see instructions)	31,421,130	0	31,421,130	0	31,421,130	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,293,084		16,293,084		30.00
31.00	03100	INTENSIVE CARE UNIT	3,716,000		3,716,000		31.00
40.00	04000	SUBPROVIDER - IPF	1,198,400		1,198,400		40.00
41.00	04100	SUBPROVIDER - IRF	975,000		975,000		41.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,983,169	14,795,809	28,778,978	0.137791	0.000000
50.01	03340	GASTRO INTESTINAL SERVICES	1,874,289	1,835,679	3,709,968	0.090981	0.000000
51.00	05100	RECOVERY ROOM	2,123,942	2,764,291	4,888,233	0.075138	0.000000
53.00	05300	ANESTHESIOLOGY	2,237,282	2,145,931	4,383,213	0.021070	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,437,231	3,609,024	6,046,255	0.203782	0.000000
54.01	03630	ULTRA SOUND	410,959	923,657	1,334,616	0.093456	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	101,732	2,176,323	2,278,055	0.152402	0.000000
56.00	05600	RADIOISOTOPE	740,807	1,517,283	2,258,090	0.140344	0.000000
56.01	03650	VASCULAR LAB	882,128	532,172	1,414,300	0.062260	0.000000
56.02	03950	STRAUSS ONCOLOGY	70,446	690,226	760,672	0.353764	0.000000
57.00	05700	CT SCAN	7,058,055	8,445,808	15,503,863	0.015379	0.000000
58.00	05800	MRI	575,506	1,398,382	1,973,888	0.043362	0.000000
59.00	05900	CARDIAC CATHETERIZATION	4,524,129	1,906,973	6,431,102	0.052310	0.000000
60.00	06000	LABORATORY	16,364,632	8,487,701	24,852,333	0.057531	0.000000
63.00	06300	BLOOD STORING PROCESSING & TRANS.	1,632,921	265,783	1,898,704	0.105202	0.000000
65.00	06500	RESPIRATORY THERAPY	2,571,181	158,665	2,729,846	0.264824	0.000000
66.00	06600	PHYSICAL THERAPY	4,222,246	2,565,479	6,787,725	0.151314	0.000000
69.00	06900	ELECTROCARDIOLOGY	3,481,423	2,713,071	6,194,494	0.079791	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	111,800	17,183	128,983	0.225689	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,806,459	4,107,223	8,913,682	0.041755	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,435,843	2,013,244	7,449,087	0.372536	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	12,055,530	14,946,674	27,002,204	0.117083	0.000000
74.00	07400	RENAL DIALYSIS	373,366	11,131	384,497	0.619597	0.000000
76.00	03951	WOUND CARE	3,564	635,577	639,141	0.353786	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,131	947,515	948,646	0.890654	0.000000
91.00	09100	EMERGENCY	4,779,572	12,104,572	16,884,144	0.104553	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	691,667	1,619,921	2,311,588	0.309845	0.000000
200.00		Subtotal (see instructions)	115,733,494	93,335,297	209,068,791		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	115,733,494	93,335,297	209,068,791		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet C
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.137791			50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0.090981			50.01
51.00	05100	RECOVERY ROOM	0.075138			51.00
53.00	05300	ANESTHESIOLOGY	0.021070			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203782			54.00
54.01	03630	ULTRA SOUND	0.093456			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.152402			55.00
56.00	05600	RADIOISOTOPE	0.140344			56.00
56.01	03650	VASCULAR LAB	0.062260			56.01
56.02	03950	STRAUSS ONCOLOGY	0.353764			56.02
57.00	05700	CT SCAN	0.015379			57.00
58.00	05800	MRI	0.043362			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.052310			59.00
60.00	06000	LABORATORY	0.057531			60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.105202			63.00
65.00	06500	RESPIRATORY THERAPY	0.264824			65.00
66.00	06600	PHYSICAL THERAPY	0.151314			66.00
69.00	06900	ELECTROCARDIOLOGY	0.079791			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.225689			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.041755			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372536			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117083			73.00
74.00	07400	RENAL DIALYSIS	0.619597			74.00
76.00	03951	WOUND CARE	0.353786			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.890654			90.00
91.00	09100	EMERGENCY	0.104553			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309845			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet D
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	661,145	0	661,145	7,782	84.96	30.00
31.00	INTENSIVE CARE UNIT	142,295		142,295	978	145.50	31.00
40.00	SUBPROVIDER - IPF	64,207	0	64,207	939	68.38	40.00
41.00	SUBPROVIDER - IRF	110,733	0	110,733	675	164.05	41.00
200.00	Total (lines 30 through 199)	978,380		978,380	10,374		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,656	225,654				
31.00	INTENSIVE CARE UNIT	417	60,674				
40.00	SUBPROVIDER - IPF	584	39,934				
41.00	SUBPROVIDER - IRF	367	60,206				
200.00	Total (lines 30 through 199)	4,024	386,468				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet D
Part II
Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	321,369	28,778,978	0.011167	5,311,362	59,312	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	39,957	3,709,968	0.010770	518,564	5,585	50.01
51.00	05100	RECOVERY ROOM	38,079	4,888,233	0.007790	853,892	6,652	51.00
53.00	05300	ANESTHESIOLOGY	5,403	4,383,213	0.001233	792,570	977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,299	6,046,255	0.022212	601,856	13,368	54.00
54.01	03630	ULTRA SOUND	3,236	1,334,616	0.002425	185,610	450	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	40,494	2,278,055	0.017776	15,745	280	55.00
56.00	05600	RADIOISOTOPE	33,093	2,258,090	0.014655	372,744	5,463	56.00
56.01	03650	VASCULAR LAB	1,249	1,414,300	0.000883	373,416	330	56.01
56.02	03950	STRAUSS ONCOLOGY	3,448	760,672	0.004533	0	0	56.02
57.00	05700	CT SCAN	13,836	15,503,863	0.000892	2,679,097	2,390	57.00
58.00	05800	MRI	11,386	1,973,888	0.005768	223,094	1,287	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,595	6,431,102	0.003047	1,980,056	6,033	59.00
60.00	06000	LABORATORY	64,252	24,852,333	0.002585	6,643,360	17,173	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	4,122	1,898,704	0.002171	439,517	954	63.00
65.00	06500	RESPIRATORY THERAPY	19,785	2,729,846	0.007248	1,078,125	7,814	65.00
66.00	06600	PHYSICAL THERAPY	48,941	6,787,725	0.007210	1,334,522	9,622	66.00
69.00	06900	ELECTROCARDIOLOGY	77,541	6,194,494	0.012518	1,477,456	18,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,602	128,983	0.012420	32,933	409	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,313	8,913,682	0.000933	2,102,132	1,961	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,112	7,449,087	0.007398	2,614,947	19,345	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,129	27,002,204	0.001671	4,320,771	7,220	73.00
74.00	07400	RENAL DIALYSIS	2,070	384,497	0.005384	192,986	1,039	74.00
76.00	03951	WOUND CARE	28,788	639,141	0.045042	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	76,349	948,646	0.080482	0	0	90.00
91.00	09100	EMERGENCY	141,588	16,884,144	0.008386	1,796,723	15,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,307	2,311,588	0.029550	237,663	7,023	92.00
200.00		Total (lines 50 through 199)	1,307,343	186,886,307		36,179,141	208,249	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part III Date/Time Prepared: 10/24/2019 1:36 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	7,782	0.00	2,656	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	978	0.00	417	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	939	0.00	584	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	675	0.00	367	41.00			
200.00		Total (lines 30 through 199)	0	0	10,374		4,024	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
31.00	03100	INTENSIVE CARE UNIT	0							31.00	
40.00	04000	SUBPROVIDER - IPF	0							40.00	
41.00	04100	SUBPROVIDER - IRF	0							41.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/24/2019 1:36 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03650	VASCULAR LAB	0	0	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY	0	0	0	0	0	56.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03951	WOUND CARE	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	28,778,978	0.000000	50.00
50.01	03340	GASTRO INTESTINAL SERVICES		0	0	0	3,709,968	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	4,888,233	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	4,383,213	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	6,046,255	0.000000	54.00
54.01	03630	ULTRA SOUND		0	0	0	1,334,616	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	2,278,055	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	2,258,090	0.000000	56.00
56.01	03650	VASCULAR LAB		0	0	0	1,414,300	0.000000	56.01
56.02	03950	STRAUSS ONCOLOGY		0	0	0	760,672	0.000000	56.02
57.00	05700	CT SCAN		0	0	0	15,503,863	0.000000	57.00
58.00	05800	MRI		0	0	0	1,973,888	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	6,431,102	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	24,852,333	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0	0	0	1,898,704	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	2,729,846	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,787,725	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	6,194,494	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	128,983	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	8,913,682	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	7,449,087	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	27,002,204	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	384,497	0.000000	74.00
76.00	03951	WOUND CARE		0	0	0	639,141	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	948,646	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	16,884,144	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,311,588	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	186,886,307		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet D
Part IV
Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	5,311,362	0	3,604,916	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0.000000	518,564	0	673,127	0	50.01
51.00	05100	RECOVERY ROOM	0.000000	853,892	0	1,107,206	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	792,570	0	483,077	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	601,856	0	1,010,988	0	54.00
54.01	03630	ULTRA SOUND	0.000000	185,610	0	262,197	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	15,745	0	1,422,063	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	372,744	0	682,341	0	56.00
56.01	03650	VASCULAR LAB	0.000000	373,416	0	277,607	0	56.01
56.02	03950	STRAUSS ONCOLOGY	0.000000	0	0	802	0	56.02
57.00	05700	CT SCAN	0.000000	2,679,097	0	3,210,312	0	57.00
58.00	05800	MRI	0.000000	223,094	0	583,590	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,980,056	0	759,097	0	59.00
60.00	06000	LABORATORY	0.000000	6,643,360	0	2,026,244	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	439,517	0	14,792	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,078,125	0	41,175	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,334,522	0	40,957	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,477,456	0	1,237,797	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	32,933	0	5,728	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,102,132	0	1,340,172	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,614,947	0	573,421	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,320,771	0	6,581,705	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	192,986	0	8,905	0	74.00
76.00	03951	WOUND CARE	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	228,140	0	90.00
91.00	09100	EMERGENCY	0.000000	1,796,723	0	2,667,190	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	237,663	0	431,553	0	92.00
200.00		Total (lines 50 through 199)		36,179,141	0	29,275,102	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet D
Part V
Date/Time Prepared:
10/24/2019 1:36 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.137791	3,604,916	0	0	496,725	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0.090981	673,127	0	0	61,242	50.01
51.00	05100	RECOVERY ROOM	0.075138	1,107,206	0	0	83,193	51.00
53.00	05300	ANESTHESIOLOGY	0.021070	483,077	0	0	10,178	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203782	1,010,988	0	0	206,021	54.00
54.01	03630	ULTRA SOUND	0.093456	262,197	0	0	24,504	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.152402	1,422,063	0	0	216,725	55.00
56.00	05600	RADIOISOTOPE	0.140344	682,341	0	0	95,762	56.00
56.01	03650	VASCULAR LAB	0.062260	277,607	0	0	17,284	56.01
56.02	03950	STRAUSS ONCOLOGY	0.353764	802	0	0	284	56.02
57.00	05700	CT SCAN	0.015379	3,210,312	0	0	49,371	57.00
58.00	05800	MRI	0.043362	583,590	0	0	25,306	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.052310	759,097	0	0	39,708	59.00
60.00	06000	LABORATORY	0.057531	2,026,244	0	0	116,572	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.105202	14,792	0	0	1,556	63.00
65.00	06500	RESPIRATORY THERAPY	0.264824	41,175	0	0	10,904	65.00
66.00	06600	PHYSICAL THERAPY	0.151314	40,957	0	0	6,197	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079791	1,237,797	0	0	98,765	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.225689	5,728	0	0	1,293	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.041755	1,340,172	0	0	55,959	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372536	573,421	0	0	213,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117083	6,581,705	0	0	770,606	73.00
74.00	07400	RENAL DIALYSIS	0.619597	8,905	0	0	5,518	74.00
76.00	03951	WOUND CARE	0.353786	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.890654	228,140	0	0	203,194	90.00
91.00	09100	EMERGENCY	0.104553	2,667,190	0	0	278,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309845	431,553	0	0	133,715	92.00
200.00		Subtotal (see instructions)		29,275,102	0	0	3,223,065	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		29,275,102	0	0	3,223,065	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet D
Part V
Date/Time Prepared:
10/24/2019 1:36 pm

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00	
50.01	03340	GASTRO INTESTINAL SERVICES	0	0	50.01	
51.00	05100	RECOVERY ROOM	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
54.01	03630	ULTRA SOUND	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00	
56.00	05600	RADIOISOTOPE	0	0	56.00	
56.01	03650	VASCULAR LAB	0	0	56.01	
56.02	03950	STRAUSS ONCOLOGY	0	0	56.02	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MRI	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00	
60.00	06000	LABORATORY	0	0	60.00	
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	74.00	
76.00	03951	WOUND CARE	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
200.00		Subtotal (see instructions)	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00	
202.00		Net Charges (line 200 - line 201)	0	0	202.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0082

Period:

Worksheet D

Component CCN: 14-S082

From 01/29/2019
To 05/31/2019Part II
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	321,369	28,778,978	0.011167	0	0 50.00
50.01	03340	GASTRO INTESTINAL SERVICES	39,957	3,709,968	0.010770	0	0 50.01
51.00	05100	RECOVERY ROOM	38,079	4,888,233	0.007790	0	0 51.00
53.00	05300	ANESTHESIOLOGY	5,403	4,383,213	0.001233	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,299	6,046,255	0.022212	15,600	347 54.00
54.01	03630	ULTRA SOUND	3,236	1,334,616	0.002425	2,951	7 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	40,494	2,278,055	0.017776	0	0 55.00
56.00	05600	RADIOISOTOPE	33,093	2,258,090	0.014655	0	0 56.00
56.01	03650	VASCULAR LAB	1,249	1,414,300	0.000883	7,252	6 56.01
56.02	03950	STRAUSS ONCOLOGY	3,448	760,672	0.004533	0	0 56.02
57.00	05700	CT SCAN	13,836	15,503,863	0.000892	46,925	42 57.00
58.00	05800	MRI	11,386	1,973,888	0.005768	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	19,595	6,431,102	0.003047	0	0 59.00
60.00	06000	LABORATORY	64,252	24,852,333	0.002585	187,664	485 60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	4,122	1,898,704	0.002171	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	19,785	2,729,846	0.007248	18,277	132 65.00
66.00	06600	PHYSICAL THERAPY	48,941	6,787,725	0.007210	62,586	451 66.00
69.00	06900	ELECTROCARDIOLOGY	77,541	6,194,494	0.012518	26,174	328 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,602	128,983	0.012420	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,313	8,913,682	0.000933	957	1 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,112	7,449,087	0.007398	97	1 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,129	27,002,204	0.001671	248,448	415 73.00
74.00	07400	RENAL DIALYSIS	2,070	384,497	0.005384	0	0 74.00
76.00	03951	WOUND CARE	28,788	639,141	0.045042	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	76,349	948,646	0.080482	0	0 90.00
91.00	09100	EMERGENCY	141,588	16,884,144	0.008386	94,280	791 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,311,588	0.000000	1,797	0 92.00
200.00		Total (lines 50 through 199)	1,239,036	186,886,307		713,008	3,006 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0082 Component CCN: 14-S082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
56.01	03650	VASCULAR LAB		0	0	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY		0	0	0	0	0	56.02
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03951	WOUND CARE		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0082 Component CCN: 14-S082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	28,778,978	0.000000	50.00
50.01	03340	GASTRO INTESTINAL SERVICES		0	0	0	3,709,968	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	4,888,233	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	4,383,213	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	6,046,255	0.000000	54.00
54.01	03630	ULTRA SOUND		0	0	0	1,334,616	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	2,278,055	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	2,258,090	0.000000	56.00
56.01	03650	VASCULAR LAB		0	0	0	1,414,300	0.000000	56.01
56.02	03950	STRAUSS ONCOLOGY		0	0	0	760,672	0.000000	56.02
57.00	05700	CT SCAN		0	0	0	15,503,863	0.000000	57.00
58.00	05800	MRI		0	0	0	1,973,888	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	6,431,102	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	24,852,333	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0	0	0	1,898,704	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	2,729,846	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,787,725	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	6,194,494	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	128,983	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	8,913,682	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	7,449,087	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	27,002,204	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	384,497	0.000000	74.00
76.00	03951	WOUND CARE		0	0	0	639,141	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	948,646	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	16,884,144	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,311,588	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	186,886,307		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0082 Component CCN: 14-S082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	15,600	0	621	0	54.00
54.01	03630	ULTRA SOUND		0.000000	2,951	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
56.01	03650	VASCULAR LAB		0.000000	7,252	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY		0.000000	0	0	0	0	56.02
57.00	05700	CT SCAN		0.000000	46,925	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	187,664	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	18,277	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	62,586	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	26,174	0	5,868	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	957	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	97	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	248,448	0	8,374	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03951	WOUND CARE		0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	94,280	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	1,797	0	0	0	92.00
200.00		Total (lines 50 through 199)			713,008	0	14,863	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0082

Period:

Worksheet D

Component CCN: 14-S082

From 01/29/2019
To 05/31/2019Part V
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.137791	0	0	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0.090981	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.075138	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.021070	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203782	621	0	0	127	54.00
54.01	03630	ULTRA SOUND	0.093456	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.152402	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.140344	0	0	0	0	56.00
56.01	03650	VASCULAR LAB	0.062260	0	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY	0.353764	0	0	0	0	56.02
57.00	05700	CT SCAN	0.015379	0	0	0	0	57.00
58.00	05800	MRI	0.043362	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.052310	0	0	0	0	59.00
60.00	06000	LABORATORY	0.057531	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.105202	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.264824	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.151314	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079791	5,868	0	0	468	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.225689	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.041755	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372536	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117083	8,374	0	0	980	73.00
74.00	07400	RENAL DIALYSIS	0.619597	0	0	0	0	74.00
76.00	03951	WOUND CARE	0.353786	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.890654	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.104553	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309845	0	0	0	0	92.00
200.00		Subtotal (see instructions)		14,863	0	0	1,575	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		14,863	0	0	1,575	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0082

Period:

Worksheet D

Component CCN: 14-S082

From 01/29/2019
To 05/31/2019Part V
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Subprovider -
IPF

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	03650	VASCULAR LAB	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY	0	0	56.02
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03951	WOUND CARE	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0082

Period:

Worksheet D

Component CCN: 14-T082

From 01/29/2019
To 05/31/2019Part II
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	321,369	28,778,978	0.011167	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	39,957	3,709,968	0.010770	0	0	50.01
51.00	05100	RECOVERY ROOM	38,079	4,888,233	0.007790	0	0	51.00
53.00	05300	ANESTHESIOLOGY	5,403	4,383,213	0.001233	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,299	6,046,255	0.022212	2,209	49	54.00
54.01	03630	ULTRA SOUND	3,236	1,334,616	0.002425	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	40,494	2,278,055	0.017776	0	0	55.00
56.00	05600	RADIOISOTOPE	33,093	2,258,090	0.014655	0	0	56.00
56.01	03650	VASCULAR LAB	1,249	1,414,300	0.000883	4,244	4	56.01
56.02	03950	STRAUSS ONCOLOGY	3,448	760,672	0.004533	0	0	56.02
57.00	05700	CT SCAN	13,836	15,503,863	0.000892	0	0	57.00
58.00	05800	MRI	11,386	1,973,888	0.005768	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,595	6,431,102	0.003047	0	0	59.00
60.00	06000	LABORATORY	64,252	24,852,333	0.002585	54,497	141	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	4,122	1,898,704	0.002171	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	19,785	2,729,846	0.007248	17,500	127	65.00
66.00	06600	PHYSICAL THERAPY	48,941	6,787,725	0.007210	645,999	4,658	66.00
69.00	06900	ELECTROCARDIOLOGY	77,541	6,194,494	0.012518	2,005	25	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,602	128,983	0.012420	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,313	8,913,682	0.000933	4,587	4	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,112	7,449,087	0.007398	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,129	27,002,204	0.001671	141,595	237	73.00
74.00	07400	RENAL DIALYSIS	2,070	384,497	0.005384	20,365	110	74.00
76.00	03951	WOUND CARE	28,788	639,141	0.045042	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	76,349	948,646	0.080482	0	0	90.00
91.00	09100	EMERGENCY	141,588	16,884,144	0.008386	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,311,588	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	1,239,036	186,886,307		893,001	5,355	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0082 Component CCN: 14-T082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
56.01	03650	VASCULAR LAB		0	0	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY		0	0	0	0	0	56.02
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03951	WOUND CARE		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0082 Component CCN: 14-T082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	28,778,978	0.000000	50.00
50.01	03340	GASTRO INTESTINAL SERVICES		0	0	0	3,709,968	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	4,888,233	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	4,383,213	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	6,046,255	0.000000	54.00
54.01	03630	ULTRA SOUND		0	0	0	1,334,616	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	2,278,055	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	2,258,090	0.000000	56.00
56.01	03650	VASCULAR LAB		0	0	0	1,414,300	0.000000	56.01
56.02	03950	STRAUSS ONCOLOGY		0	0	0	760,672	0.000000	56.02
57.00	05700	CT SCAN		0	0	0	15,503,863	0.000000	57.00
58.00	05800	MRI		0	0	0	1,973,888	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	6,431,102	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	24,852,333	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0	0	0	1,898,704	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	2,729,846	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,787,725	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	6,194,494	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	128,983	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	8,913,682	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	7,449,087	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	27,002,204	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	384,497	0.000000	74.00
76.00	03951	WOUND CARE		0	0	0	639,141	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	948,646	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	16,884,144	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,311,588	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	186,886,307		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0082 Component CCN: 14-T082		Period: From 01/29/2019 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	2,209	0	1,012	0	54.00
54.01	03630	ULTRA SOUND		0.000000	0	0	647	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
56.01	03650	VASCULAR LAB		0.000000	4,244	0	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY		0.000000	0	0	0	0	56.02
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	54,497	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	17,500	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	645,999	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	2,005	0	451	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	4,587	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	141,595	0	147	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	20,365	0	0	0	74.00
76.00	03951	WOUND CARE		0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			893,001	0	2,257	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0082

Period:

Worksheet D

Component CCN: 14-T082

From 01/29/2019
To 05/31/2019Part V
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.137791	0	0	0	0 50.00
50.01	03340 GASTRO INTESTINAL SERVICES	0.090981	0	0	0	0 50.01
51.00	05100 RECOVERY ROOM	0.075138	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.021070	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203782	1,012	0	0	206 54.00
54.01	03630 ULTRA SOUND	0.093456	647	0	0	60 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.152402	0	0	0	0 55.00
56.00	05600 RADIOISOTOPE	0.140344	0	0	0	0 56.00
56.01	03650 VASCULAR LAB	0.062260	0	0	0	0 56.01
56.02	03950 STRAUSS ONCOLOGY	0.353764	0	0	0	0 56.02
57.00	05700 CT SCAN	0.015379	0	0	0	0 57.00
58.00	05800 MRI	0.043362	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.052310	0	0	0	0 59.00
60.00	06000 LABORATORY	0.057531	0	0	0	0 60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.105202	0	0	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.264824	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.151314	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.079791	451	0	0	36 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.225689	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.041755	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.372536	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117083	147	0	0	17 73.00
74.00	07400 RENAL DIALYSIS	0.619597	0	0	0	0 74.00
76.00	03951 WOUND CARE	0.353786	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.890654	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.104553	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.309845	0	0	0	0 92.00
200.00	Subtotal (see instructions)		2,257	0	0	319 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		2,257	0	0	319 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0082

Period:

Worksheet D

Component CCN: 14-T082

From 01/29/2019
To 05/31/2019Part V
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Subprovider -
IRF

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	03650	VASCULAR LAB	0	0	56.01
56.02	03950	STRAUSS ONCOLOGY	0	0	56.02
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03951	WOUND CARE	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,782	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,782	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,978	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,656	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,932,520	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,932,520	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,932,520	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		890.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,366,071	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,366,071	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet D-1

Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,716,374	978	1,754.98	417	731,827	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,222,398	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,320,296	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					286,328	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					208,249	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					494,577	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,825,719	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					804	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					890.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					716,235	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet D-1

Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	661,145	6,932,520	0.095369	716,235	68,307
91.00	Nursing School cost	0	6,932,520	0.000000	716,235	0
92.00	Allied health cost	0	6,932,520	0.000000	716,235	0
93.00	All other Medical Education	0	6,932,520	0.000000	716,235	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet D-1
		Component CCN: 14-S082		Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		939	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		939	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		939	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		584	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		831,701	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		831,701	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		831,701	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		885.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		517,266	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		517,266	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet D-1	
				Component CCN: 14-S082		Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
		Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT		0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					71,402	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					588,668	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					39,934	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,006	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					42,940	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					545,728	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0082

Period:

Worksheet D-1

Component CCN: 14-S082

From 01/29/2019

Date/Time Prepared:

To 05/31/2019

10/24/2019 1:36 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	64,207	831,701	0.077200	0	0	90.00
91.00	Nursing School cost	0	831,701	0.000000	0	0	91.00
92.00	Allied health cost	0	831,701	0.000000	0	0	92.00
93.00	All other Medical Education	0	831,701	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet D-1
		Component CCN: 14-T082		Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		675	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		675	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		675	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		367	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		853,147	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		853,147	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		853,147	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,263.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		463,859	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		463,859	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet D-1	
				Component CCN: 14-T082		Date/Time Prepared: 10/24/2019 1:36 pm	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					135,780	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					599,639	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					60,206	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,355	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					65,561	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					534,078	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0082 Component CCN: 14-T082		Period: From 01/29/2019 To 05/31/2019		Worksheet D-1 Date/Time Prepared: 10/24/2019 1:36 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	110,733	853,147	0.129794	0	0	90.00
91.00	Nursing School cost	0	853,147	0.000000	0	0	91.00
92.00	Allied health cost	0	853,147	0.000000	0	0	92.00
93.00	All other Medical Education	0	853,147	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet D-3 Date/Time Prepared: 10/24/2019 1:36 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		6,549,400	30.00
31.00	03100	INTENSIVE CARE UNIT		1,584,600	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.137791	5,311,362	50.00
50.01	03340	GASTRO INTESTINAL SERVICES	0.090981	518,564	50.01
51.00	05100	RECOVERY ROOM	0.075138	853,892	51.00
53.00	05300	ANESTHESIOLOGY	0.021070	792,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203782	601,856	54.00
54.01	03630	ULTRA SOUND	0.093456	185,610	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.152402	15,745	55.00
56.00	05600	RADIOISOTOPE	0.140344	372,744	56.00
56.01	03650	VASCULAR LAB	0.062260	373,416	56.01
56.02	03950	STRAUSS ONCOLOGY	0.353764	0	56.02
57.00	05700	CT SCAN	0.015379	2,679,097	57.00
58.00	05800	MRI	0.043362	223,094	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.052310	1,980,056	59.00
60.00	06000	LABORATORY	0.057531	6,643,360	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.105202	439,517	63.00
65.00	06500	RESPIRATORY THERAPY	0.264824	1,078,125	65.00
66.00	06600	PHYSICAL THERAPY	0.151314	1,334,522	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079791	1,477,456	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.225689	32,933	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.041755	2,102,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372536	2,614,947	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117083	4,320,771	73.00
74.00	07400	RENAL DIALYSIS	0.619597	192,986	74.00
76.00	03951	WOUND CARE	0.353786	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.890654	0	90.00
91.00	09100	EMERGENCY	0.104553	1,796,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309845	237,663	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		36,179,141	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		36,179,141	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0082 Component CCN: 14-S082	Period: From 01/29/2019 To 05/31/2019	Worksheet D-3 Date/Time Prepared: 10/24/2019 1:36 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,800		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		699,600		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.137791	0	0	50.00
50.01	03340 GASTRO INTESTINAL SERVICES	0.090981	0	0	50.01
51.00	05100 RECOVERY ROOM	0.075138	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.021070	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203782	15,600	3,179	54.00
54.01	03630 ULTRA SOUND	0.093456	2,951	276	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.152402	0	0	55.00
56.00	05600 RADIOISOTOPE	0.140344	0	0	56.00
56.01	03650 VASCULAR LAB	0.062260	7,252	452	56.01
56.02	03950 STRAUSS ONCOLOGY	0.353764	0	0	56.02
57.00	05700 CT SCAN	0.015379	46,925	722	57.00
58.00	05800 MRI	0.043362	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.052310	0	0	59.00
60.00	06000 LABORATORY	0.057531	187,664	10,796	60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.105202	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.264824	18,277	4,840	65.00
66.00	06600 PHYSICAL THERAPY	0.151314	62,586	9,470	66.00
69.00	06900 ELECTROCARDIOLOGY	0.079791	26,174	2,088	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.225689	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.041755	957	40	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.372536	97	36	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117083	248,448	29,089	73.00
74.00	07400 RENAL DIALYSIS	0.619597	0	0	74.00
76.00	03951 WOUND CARE	0.353786	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.890654	0	0	90.00
91.00	09100 EMERGENCY	0.104553	94,280	9,857	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.309845	1,797	557	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		713,008	71,402	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		713,008		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0082 Component CCN: 14-T082	Period: From 01/29/2019 To 05/31/2019	Worksheet D-3 Date/Time Prepared: 10/24/2019 1:36 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		550,500		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.137791	0	0	50.00
50.01	03340 GASTRO INTESTINAL SERVICES	0.090981	0	0	50.01
51.00	05100 RECOVERY ROOM	0.075138	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.021070	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203782	2,209	450	54.00
54.01	03630 ULTRA SOUND	0.093456	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.152402	0	0	55.00
56.00	05600 RADIOISOTOPE	0.140344	0	0	56.00
56.01	03650 VASCULAR LAB	0.062260	4,244	264	56.01
56.02	03950 STRAUSS ONCOLOGY	0.353764	0	0	56.02
57.00	05700 CT SCAN	0.015379	0	0	57.00
58.00	05800 MRI	0.043362	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.052310	0	0	59.00
60.00	06000 LABORATORY	0.057531	54,497	3,135	60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.105202	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.264824	17,500	4,634	65.00
66.00	06600 PHYSICAL THERAPY	0.151314	645,999	97,749	66.00
69.00	06900 ELECTROCARDIOLOGY	0.079791	2,005	160	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.225689	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.041755	4,587	192	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.372536	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117083	141,595	16,578	73.00
74.00	07400 RENAL DIALYSIS	0.619597	20,365	12,618	74.00
76.00	03951 WOUND CARE	0.353786	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.890654	0	0	90.00
91.00	09100 EMERGENCY	0.104553	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.309845	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		893,001	135,780	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		893,001	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet E
Part A
Date/Time Prepared:
10/24/2019 1:36 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			6,211,236	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			19,958	2.04
3.00	Managed Care Simulated Payments			2,248,328	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			112.46	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			73.13	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			1.41	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			4.46	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			10.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			77.26	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			66.38	10.00
11.00	FTE count for residents in dental and podiatric programs.			16.44	11.00
12.00	Current year allowable FTE (see instructions)			82.82	12.00
13.00	Total allowable FTE count for the prior year.			82.26	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			69.59	14.00
15.00	Sum of lines 12 through 14 divided by 3.			78.22	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			78.22	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.695536	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.731851	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.695536	21.00
22.00	IME payment adjustment (see instructions)			1,999,223	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			723,674	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			-10.88	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			1,999,223	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			723,674	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			11.40	30.00
31.00	Percentage of Medicaid patient days (see instructions)			24.17	31.00
32.00	Sum of lines 30 and 31			35.57	32.00
33.00	Allowable disproportionate share percentage (see instructions)			18.56	33.00
34.00	Disproportionate share adjustment (see instructions)			288,201	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet E Part A Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,240,453	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	418,015	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	418,015		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	8,936,633		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		9,660,307	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		712,117	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		1,375,717	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		11,748,141	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,748,141	61.00
62.00	Deductibles billed to program beneficiaries		508,676	62.00
63.00	Coinurance billed to program beneficiaries		59,334	63.00
64.00	Allowable bad debts (see instructions)		348,979	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		226,836	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		273,214	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,406,967	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-29,709	70.93
70.94	HRR adjustment amount (see instructions)		-17,391	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet E
Part A
Date/Time Prepared:
10/24/2019 1:36 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		95,817	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,264,050	71.00	
71.01	Sequestration adjustment (see instructions)		225,281	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		10,618,789	72.00	
73.00	Tentative settlement (for contractor use only)		0	73.00	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		419,980	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		120,252	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
10/24/2019 1:36 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,211,236	0	6,211,236		6,211,236	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	19,958		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	19,958	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,248,328	0	2,248,328	0	2,248,328	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.695536	0.695536	0.695536	0.695536		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,999,223	0	1,999,223	0	1,999,223	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	723,674	0	723,674	0	723,674	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,999,223	0	1,999,223	0	1,999,223	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	723,674	0	723,674	0	723,674	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1856	0.1856	0.1856	0.1856		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	288,201	0	288,201	0	288,201	11.00
11.01	Uncompensated care payments	36.00	418,015	0	418,015	0	418,015	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,936,633	0	8,936,633	0	8,936,633	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,660,307	0	9,660,307	0	9,660,307	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	712,117	0	712,117	0	712,117	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
10/24/2019 1:36 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	10,372,424	0	10,372,424
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	505,312	0	505,312	0	505,312
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	1,244	0	1,244	0	1,244
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.4068	0.4068	0.4068	0.4068	
23.00	Indirect medical education adjustment (see instructions)	6.00	205,561	0	205,561	0	205,561
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	712,117	0	712,117	0	712,117
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
10/24/2019 1:36 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,211,236	6,211,236		6,211,236	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	19,958		19,958	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,248,328	0	2,248,328	2,248,328	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.695536	0.695536	0.695536		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,999,223	1,999,223	0	1,999,223	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	723,674	0	723,674	723,674	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,999,223	1,999,223	0	1,999,223	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	723,674	0	723,674	723,674	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1856	0.1856	0.1856		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	288,201	288,201	0	288,201	11.00
11.01	Uncompensated care payments	36.00	418,015	418,015	0	418,015	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,936,633	8,916,675	19,958	8,936,633	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,660,307	8,916,675	743,632	9,660,307	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	712,117	712,117	0	712,117	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,628,792	743,632	10,372,424	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
10/24/2019 1:36 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	505,312	505,312	0	505,312	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,244	1,244	0	1,244	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.4068	0.4068	0.4068		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	205,561	205,561	0	205,561	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	712,117	712,117	0	712,117	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-29,709	-29,709	0	-29,709	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-17,391	-17,391	0	-17,391	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		95,817	0	95,817	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet E Part B Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,223,065	2.00
3.00	OPPS payments		2,855,250	3.00
4.00	Outlier payment (see instructions)		15,309	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		2,870,559	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		594,631	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,275,928	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		521,298	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,797,226	30.00
31.00	Primary payer payments		809	31.00
32.00	Subtotal (line 30 minus line 31)		2,796,417	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		314,472	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		204,407	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		267,611	36.00
37.00	Subtotal (see instructions)		3,000,824	37.00
38.00	MSP-LCC reconciliation amount from PS&R		8	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,000,816	40.00
40.01	Sequestration adjustment (see instructions)		60,016	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,820,475	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		120,325	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0082 Component CCN: 14-S082	Period: From 01/29/2019 To 05/31/2019	Worksheet E Part B Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		1,575	2.00
3.00	OPPI payments		743	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		743	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		149	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		594	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		594	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		594	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		594	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		594	40.00
40.01	Sequestration adjustment (see instructions)		12	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		583	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0082 Component CCN: 14-T082	Period: From 01/29/2019 To 05/31/2019	Worksheet E Part B Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		319	2.00
3.00	OPPS payments		339	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		339	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		68	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		271	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		271	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		271	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		271	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		271	40.00
40.01	Sequestration adjustment (see instructions)		5	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		266	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet E-1
Part I
Date/Time Prepared:
10/24/2019 1:36 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,466,011		2,817,845	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/15/2019	152,778	05/15/2019	2,630	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		152,778		2,630	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,618,789		2,820,475	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		419,980		120,325	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,038,769		2,940,800	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0082

Period:

Worksheet E-1

Component CCN: 14-S082

From 01/29/2019
To 05/31/2019Part I
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		529,126		583	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		529,126		583	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		529,126		582	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0082

Period:

Worksheet E-1

Component CCN: 14-T082

From 01/29/2019
To 05/31/2019Part I
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		643,146		266	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/15/2019	23,222		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		23,222		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		666,368		266	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		33,412		0	6.02
7.00	Total Medicare program liability (see instructions)		632,956		266	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet E-1
Part II
Date/Time Prepared:
10/24/2019 1:36 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	8.00
9.00	Sequestration adjustment amount (see instructions)	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	30.00
31.00	Other Adjustment (specify)	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0082 Component CCN: 14-S082	Period: From 01/29/2019 To 05/31/2019	Worksheet E-3 Part II Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		575,389	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		7.634146	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		575,389	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		575,389	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		575,389	18.00
19.00	Deductibles		35,464	19.00
20.00	Subtotal (line 18 minus line 19)		539,925	20.00
21.00	Coinsurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		539,925	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		539,925	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		539,925	31.00
31.01	Sequestration adjustment (see instructions)		10,799	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		529,126	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0082 Component CCN: 14-T082	Period: From 01/29/2019 To 05/31/2019	Worksheet E-3 Part III Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			601,502 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.1168 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			51,910 3.00
4.00	Outlier Payments			2,691 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			5.487805 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			656,103 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			656,103 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			656,103 19.00
20.00	Deductibles			2,728 20.00
21.00	Subtotal (line 19 minus line 20)			653,375 21.00
22.00	Coinsurance			7,502 22.00
23.00	Subtotal (line 21 minus line 22)			645,873 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			645,873 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			645,873 32.00
32.01	Sequestration adjustment (see instructions)			12,917 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			666,368 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-33,412 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			2,691 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet E-4 Date/Time Prepared: 10/24/2019 1:36 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			19.68	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.09	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.21	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.49	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			3.37	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			22.24	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			22.37	6.00
7.00	Enter the lesser of line 5 or line 6			22.24	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	13.41	8.68	22.09	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	13.33	8.63	21.96	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		4.90		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		5.54		10.01
11.00	Total weighted FTE count	13.33	13.53		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	14.22	12.65		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	13.53	11.07		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	13.69	12.42		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	13.69	12.42		17.00
18.00	Per resident amount	134,456.94	127,318.90		18.00
19.00	Approved amount for resident costs	1,840,716	1,581,301	3,422,017	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.13	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			3,422,017	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	4,024	1,492		26.00
27.00	Total Inpatient Days (see instructions)	9,570	9,570		27.00
28.00	Ratio of inpatient days to total inpatient days	0.420481	0.155904		28.00
29.00	Program direct GME amount	1,438,893	533,506		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		75,384		30.00
31.00	Net Program direct GME amount			1,897,015	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet E-4 Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Hospital	PPS
				1.00
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		384,497	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		8,508,603	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		8,508,603	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		3,224,959	42.00
43.00	Primary payer payments (see instructions)		809	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		3,224,150	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		11,732,753	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.725201	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.274799	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		1,897,015	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		1,375,717	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		521,298	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet G

Date/Time Prepared:
10/24/2019 1:36 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,716,262	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	51,292,048	0	0	0	4.00
5.00	Other receivable	368,282	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-34,504,299	0	0	0	6.00
7.00	Inventory	3,260,024	0	0	0	7.00
8.00	Prepaid expenses	754,225	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,886,542	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	14,837	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,028,062	0	0	0	23.00
24.00	Accumulated depreciation	-825,930	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,216,969	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,103,511	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	13,244,628	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,765,514	0	0	0	38.00
39.00	Payroll taxes payable	2,703,002	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-5,511,539	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,201,605	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	945,561	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,012,257	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,957,818	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,159,423	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,944,088				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,944,088	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,103,511	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet G-1

Date/Time Prepared:
10/24/2019 1:36 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		12,561,078		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,616,990				2.00
3.00	Total (sum of line 1 and line 2)		10,944,088		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,944,088		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,944,088		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
10/24/2019 1:36 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	16,293,084		16,293,084	1.00
2.00	SUBPROVIDER - IPF	1,198,400		1,198,400	2.00
3.00	SUBPROVIDER - IRF	975,000		975,000	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	18,466,484		18,466,484	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,716,000		3,716,000	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,716,000		3,716,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,182,484		22,182,484	17.00
18.00	Ancillary services	88,078,640	78,663,289	166,741,929	18.00
19.00	Outpatient services	5,472,370	14,672,008	20,144,378	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN CLINICS	0	325,182	325,182	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	115,733,494	93,660,479	209,393,973	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,603,134		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		37,603,134		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0082

Period:
From 01/29/2019
To 05/31/2019

Worksheet G-3

Date/Time Prepared:
10/24/2019 1:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	209,393,973	1.00
2.00	Less contractual allowances and discounts on patients' accounts	173,701,157	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,692,816	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,603,134	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,910,318	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	141,405	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	134	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	137,887	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS/OTHER REVENUE	13,902	24.00
25.00	Total other income (sum of lines 6-24)	293,328	25.00
26.00	Total (line 5 plus line 25)	-1,616,990	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,616,990	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0082	Period: From 01/29/2019 To 05/31/2019	Worksheet L Parts I-III Date/Time Prepared: 10/24/2019 1:36 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		505,312	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,244	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		64.68	3.00
4.00	Number of interns & residents (see instructions)		78.22	4.00
5.00	Indirect medical education percentage (see instructions)		40.68	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		205,561	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		712,117	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00