

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/28/2020 3:07 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/28/2020	Time: 3:07 pm
	2. ☐ Manually prepared 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 GATEWAY REGIONAL (14-0125) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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) PATRICK GARVEY

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

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	-42,619	-73,876	0	0	1.00
2.00	Subprovider - IPF	0	-28,671	-37		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-71,290	-73,913	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: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 3:07 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2100 MADISON AVE			PO Box:				1.00	
2.00	City: GRANITE CITY			State: IL		Zip Code: 62040		County: MADISON	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			GATEWAY REGIONAL	140125	41180	1	07/01/1969	N
4.00	Subprovider - IPF			PSYCH DPU	14S125	41180	4	01/01/1984	N
5.00	Subprovider - IRF								P
6.00	Subprovider - (Other)								P
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)						01/01/2019	12/31/2019	
21.00	Type of Control (see instructions)						4		
							1.00	2.00	
							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		
22.01	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		
22.02	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		
22.03	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	
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		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.			0	11,180	0	810	0	50

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 3:07 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	0		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.					1		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.					1		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)					N	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	Y	N	
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	
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	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			
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.								
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			
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			
				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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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	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)				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)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
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.						
64.00 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)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 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)		0.00	0.00	0.000000	66.00		
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	76.00

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			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.	N	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.	N	N	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)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		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	Respiratory
		1.00	2.00	3.00	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.	N	N	N	N
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 3:07 pm
		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
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
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		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		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:	329,997	150,316	0118.01
		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	Removed and reserved			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)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 3:07 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: QUORUM HEALTH CORPORATION		Contractor's Name: WPS		Contractor's Number: 52280				141.00
142.00	Street: 1573 MALLORY LANE		PO Box: SUITE 100						142.00
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027				143.00
									1.00
144.00	Are provider based physicians' costs included in Worksheet A?								Y
									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				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
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				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		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
									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
		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		
									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
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)								
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)								
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
						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)								
						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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 3:07 pm
			Y/N 1.00	Date 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)	N		1.00
		Y/N 1.00	Date 2.00	V/I 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)	Y		3.00
		Y/N 1.00	Type 2.00	Date 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		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 1.00	Legal Oper. 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.	N		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.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 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	04/20/2020	Y
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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/28/2020 3:07 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		N		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.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		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.		N		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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		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.		N		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.		N		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.		Y		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.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		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.		Y		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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		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.	LUCIE	GREENE		41.00
42.00	Enter the employer/company name of the cost report preparer.	QHC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 221-3747	LUCIE_GREENE@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 3:07 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.	SENIOR DIRECTOR, REIMBURSEMENT		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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 3:07 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	276	100,740	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)		276	100,740	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	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	43.00				0	13.00
14.00 Total (see instructions)		288	105,120	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	17	6,205		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	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)		305			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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 3:07 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)	5,384	4,726	25,653			1.00
2.00	HMO and other (see instructions)	2,140	7,066				2.00
3.00	HMO IPF Subprovider	287	0				3.00
4.00	HMO IRF Subprovider	0	0				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)	5,384	4,726	25,653			7.00
8.00	INTENSIVE CARE UNIT	488	45	1,236			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		121	521			13.00
14.00	Total (see instructions)	5,872	4,892	27,410	0.00	541.08	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,939	82	4,128	0.00	22.55	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	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)				0.00	563.63	27.00
28.00	Observation Bed Days		0	2,218			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	82	109			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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 3:07 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	1,219	929	5,967	1.00
2.00 HMO and other (see instructions)			450	1,755		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		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	1,219	929	5,967	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	206	172	531	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/28/2020 3:07 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	33,553,668	0	33,553,668	1,172,340.00	28.62
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,456,054	158,998	1,615,052	53,212.00	30.35
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,053,969	0	3,053,969	66,792.00	45.72
12.00	Contract labor: Top level management and other management and administrative services		49,773	0	49,773	508.00	97.98
13.00	Contract labor: Physician-Part A - Administrative		221,085	0	221,085	2,463.00	89.76
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		2,117,982	0	2,117,982	27,594.00	76.76
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,000,705	0	7,000,705		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		343,375	0	343,375		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/28/2020 3:07 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	317,772	0	317,772	10,424.00	30.48	26.00
27.00	Administrative & General	5.00	4,101,400	473,409	4,574,809	175,821.00	26.02	27.00
28.00	Administrative & General under contract (see inst.)		4,165	0	4,165	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	948,695	0	948,695	34,676.00	27.36	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		745,161	0	745,161	111,351.00	6.69	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		593,721	0	593,721	39,377.00	15.08	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	2,612,138	0	2,612,138	75,539.00	34.58	38.00
39.00	Central Services and Supply	14.00	205,610	0	205,610	11,409.00	18.02	39.00
40.00	Pharmacy	15.00	1,366,411	0	1,366,411	37,900.00	36.05	40.00
41.00	Medical Records & Medical Records Library	16.00	550,580	0	550,580	29,760.00	18.50	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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/28/2020 3:07 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)	34,896,715	0	34,896,715	1,323,068.00	26.38	1.00
2.00	Excluded area salaries (see instructions)	1,456,054	158,998	1,615,052	53,212.00	30.35	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,440,661	-158,998	33,281,663	1,269,856.00	26.21	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,442,809	0	5,442,809	97,357.00	55.91	4.00
5.00	Subtotal wage-related costs (see inst.)	7,000,705	0	7,000,705	0.00	21.03	5.00
6.00	Total (sum of lines 3 thru 5)	45,884,175	-158,998	45,725,177	1,367,213.00	33.44	6.00
7.00	Total overhead cost (see instructions)	11,445,653	473,409	11,919,062	526,257.00	22.65	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/28/2020 3:07 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	552,270	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)	3,672,558	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	28,731	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	21,683	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-1,728	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	18,692	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	320,414	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	2,053,954	17.00
18.00	Medicare Taxes - Employers Portion Only	480,360	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	204,400	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,351,334	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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/28/2020 3:07 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	3,054,969	7,351,334	1.00
2.00	Hospital	3,054,969	7,351,334	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	0	0	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: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/28/2020 3:07 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)			0.096114	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			17,552,728	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			13,327,023	5.00
6.00	Medicaid charges			301,182,180	6.00
7.00	Medicaid cost (line 1 times line 6)			28,947,824	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)			0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			2,971	9.00
10.00	Stand-alone CHIP charges			16,140	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			1,551	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)			0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	16,265,460	0	16,265,460	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,563,338	0	1,563,338	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,563,338	0	1,563,338	23.00
				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)			21,930,728	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			350,097	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			538,611	27.01
28.00	Non-Medicare bad debt expense (see instructions)			21,392,117	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,244,596	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,807,934	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,807,934	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati 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		2,755,357	2,755,357	1,288,503	4,043,860 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,896,390	2,896,390	1,145,978	4,042,368 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	317,772	107,196	424,968	5,495,262	5,920,230 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,101,400	29,129,009	33,230,409	-5,766,203	27,464,206 5.00
7.00	00700	OPERATION OF PLANT	948,695	4,588,880	5,537,575	-132,677	5,404,898 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	310,971	310,971	0	310,971 8.00
9.00	00900	HOUSEKEEPING	0	1,778,134	1,778,134	0	1,778,134 9.00
10.00	01000	DIETARY	0	1,993,587	1,993,587	-1,043,836	949,751 10.00
11.00	01100	CAFETERIA	0	0	0	1,043,836	1,043,836 11.00
13.00	01300	NURSING ADMINISTRATION	2,612,138	1,367,006	3,979,144	-834,725	3,144,419 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	205,610	164,091	369,701	24,101	393,802 14.00
15.00	01500	PHARMACY	1,366,411	1,553,994	2,920,405	-1,267,272	1,653,133 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	550,580	897,244	1,447,824	-5,754	1,442,070 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,623,577	4,259,917	11,883,494	246,868	12,130,362 30.00
31.00	03100	INTENSIVE CARE UNIT	919,852	1,900,671	2,820,523	-6,048	2,820,475 31.00
40.00	04000	SUBPROVIDER - IPF	1,397,371	365,380	1,762,751	0	1,762,751 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
43.00	04300	NURSERY	137,522	773,143	910,665	14,318	924,983 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,586,128	6,350,922	7,937,050	-3,237,486	4,699,564 50.00
51.00	05100	RECOVERY ROOM	189,161	79,569	268,730	0	268,730 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	726,738	274,099	1,000,837	-274,069	726,768 52.00
53.00	05300	ANESTHESIOLOGY	0	1,566,059	1,566,059	-19,679	1,546,380 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,428,171	1,323,173	2,751,344	894,625	3,645,969 54.00
54.01	05401	ULTRA-SOUND	138,057	44,082	182,139	-182,139	0 54.01
56.00	05600	RADIOISOTOPE	80,515	108,664	189,179	-189,179	0 56.00
57.00	05700	CT SCAN	318,766	380,375	699,141	-699,141	0 57.00
58.00	05800	MRI	127,427	86,135	213,562	-213,562	0 58.00
60.00	06000	LABORATORY	2,726,045	2,336,217	5,062,262	-100,927	4,961,335 60.00
65.00	06500	RESPIRATORY THERAPY	652,246	257,203	909,449	-110,789	798,660 65.00
66.00	06600	PHYSICAL THERAPY	782,458	119,445	901,903	177,510	1,079,413 66.00
67.00	06700	OCCUPATIONAL THERAPY	135,927	10,408	146,335	-146,335	0 67.00
68.00	06800	SPEECH PATHOLOGY	30,423	2,797	33,220	-33,220	0 68.00
69.00	06900	ELECTROCARDIOLOGY	806,671	1,487,021	2,293,692	-327,671	1,966,021 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	202,186	202,186 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,388,953	3,388,953 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,145,059	1,145,059 73.00
74.00	07400	RENAL DIALYSIS	0	184,809	184,809	0	184,809 74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	182,581	98,081	280,662	-897	279,765 76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	672,271	164,080	836,351	-726,637	109,714 76.02
76.03	03950	WOUND CARE	109,148	146,524	255,672	-6,610	249,062 76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	740,624	2,131,010	2,871,634	-255,551	2,616,083 90.00
91.00	09100	EMERGENCY	1,880,700	3,224,130	5,104,830	-5,355	5,099,475 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,494,985	75,221,773	108,716,758	-518,563	108,198,195 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,382	315,072	317,454	106,424	423,878 192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0 194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	405,787	405,787 194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	56,301	13,906	70,207	6,352	76,559 194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0 194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	33,553,668	75,550,751	109,104,419	0	109,104,419 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
8/28/2020 3:07 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	-897,341	3,146,519	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-58,002	3,984,366	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,982	5,913,248	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,034,390	14,429,816	5.00
7.00	00700	OPERATION OF PLANT	0	5,404,898	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	310,971	8.00
9.00	00900	HOUSEKEEPING	0	1,778,134	9.00
10.00	01000	DIETARY	0	949,751	10.00
11.00	01100	CAFETERIA	-260,976	782,860	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,144,419	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	393,802	14.00
15.00	01500	PHARMACY	0	1,653,133	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-184	1,441,886	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,778,321	9,352,041	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,384,945	1,435,530	31.00
40.00	04000	SUBPROVIDER - IPF	-234,453	1,528,298	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	-140,936	784,047	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,699,564	50.00
51.00	05100	RECOVERY ROOM	0	268,730	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-334,078	392,690	52.00
53.00	05300	ANESTHESIOLOGY	-1,450,531	95,849	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-210,878	3,435,091	54.00
54.01	05401	ULTRA-SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-18,274	4,943,061	60.00
65.00	06500	RESPIRATORY THERAPY	0	798,660	65.00
66.00	06600	PHYSICAL THERAPY	0	1,079,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,966,021	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	202,186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,388,953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-20	1,145,039	73.00
74.00	07400	RENAL DIALYSIS	0	184,809	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	0	279,765	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-64,085	45,629	76.02
76.03	03950	WOUND CARE	0	249,062	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	2,616,083	90.00
91.00	09100	EMERGENCY	-3,405,578	1,693,897	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)	-24,279,974	83,918,221	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	423,878	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	405,787	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	76,559	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-24,279,974	84,824,445	200.00

RECLASSIFICATIONS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

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 - RECLASS OF EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,495,262		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
	0		0	5,495,262		
	B - RECLASS OF OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	79,753		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
	0		0	79,753		
	C - RECLASS OF RENTAL AND LEASE EXPENSES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,134,158		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	106,424		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
	0		0	1,240,582		
	D - RECLASS OF OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	194,299		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,094,204		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,820		3.00
	0		0	1,300,323		
	E - RECLASS OF MARKETING DEPARTMENTS					
1.00	OTHER NONREIMB - MARKETING	194.01	158,998	246,789		1.00
	0		158,998	246,789		
	F - RECLASS OF MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	31,741		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	122,433		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,388,953		3.00
	0		0	3,543,127		
	G - RECLASS OF COST OF DRUGS/IV SOLUTION					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,145,059		1.00
	0		0	1,145,059		
	H - RECLASS OF PT, OT, AND SP COSTS					
1.00	PHYSICAL THERAPY	66.00	166,350	13,205		1.00
2.00		0.00	0	0		2.00
	0		166,350	13,205		
	I - RECLASS OF MISC DEPARTMENTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	632,407	95,075		1.00
2.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	2,045		2.00
3.00	OTHER NONREIMB - SENIOR CIRCLE	194.02	0	6,352		3.00
	0		632,407	103,472		
	J - RECLASS OF OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	664,765	619,256		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
	0		664,765	619,256		
	K - RECLASS OF A PORTION OF DIETARY COST					
1.00	CAFETERIA	11.00	0	1,043,836		1.00
	0		0	1,043,836		

RECLASSIFICATIONS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	M - OB/GYN COSTS					
1.00	ADULTS & PEDIATRICS	30.00	11,562	248,189		1.00
2.00	NURSERY	43.00	14,318	0		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	334,078		3.00
	0		25,880	582,267		
500.00	Grand Total: Increases		1,648,400	15,412,931		500.00

RECLASSIFICATIONS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet 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 - RECLASS OF EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,617,177	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	834,725	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	12,883	0		3.00
4.00	OPERATING ROOM	50.00	0	3,860	0		4.00
5.00	LABORATORY	60.00	0	20,366	0		5.00
6.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	1,200	0		6.00
7.00	EMERGENCY	91.00	0	5,051	0		7.00
0			0	5,495,262			
	B - RECLASS OF OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	970	0		1.00
2.00	LABORATORY	60.00	0	51	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	71,912	0		3.00
4.00	WOUND CARE	76.03	0	6,516	0		4.00
5.00	EMERGENCY	91.00	0	304	0		5.00
0			0	79,753			
	C - RECLASS OF RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	164,046	10		1.00
2.00	OPERATION OF PLANT	7.00	0	132,677	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,640	0		3.00
4.00	PHARMACY	15.00	0	122,213	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,754	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	6,048	0		6.00
7.00	OPERATING ROOM	50.00	0	17,200	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	19,679	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	389,396	0		9.00
10.00	LABORATORY	60.00	0	80,510	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	38,877	0		11.00
12.00	SLEEP LAB	76.01	0	897	0		12.00
13.00	WOUND CARE	76.03	0	94	0		13.00
14.00	CLINIC	90.00	0	255,551	0		14.00
0			0	1,240,582			
	D - RECLASS OF OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,300,323	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
0			0	1,300,323			
	E - RECLASS OF MARKETING DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	158,998	246,789	0		1.00
0			158,998	246,789			
	F - RECLASS OF MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	3,215,456	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	327,671	0		2.00
3.00		0.00	0	0	0		3.00
0			0	3,543,127			
	G - RECLASS OF COST OF DRUGS/IV SOLUTION						
1.00	PHARMACY	15.00	0	1,145,059	0		1.00
0			0	1,145,059			
	H - RECLASS OF PT, OT, AND SP COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	135,927	10,408	0		1.00
2.00	SPEECH PATHOLOGY	68.00	30,423	2,797	0		2.00
0			166,350	13,205			
	I - RECLASS OF MISC DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,352	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	2,045	0		2.00
3.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	632,407	95,075	0		3.00
0			632,407	103,472			
	J - RECLASS OF OTHER RADIOLOGY COSTS						
1.00	ULTRA-SOUND	54.01	138,057	44,082	0		1.00
2.00	RADIOISOTOPE	56.00	80,515	108,664	0		2.00
3.00	CT SCAN	57.00	318,766	380,375	0		3.00
4.00	MRI	58.00	127,427	86,135	0		4.00
0			664,765	619,256			
	K - RECLASS OF A PORTION OF DIETARY COST						
1.00	DIETARY	10.00	0	1,043,836	0		1.00
0			0	1,043,836			
	M - OB/GYN COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	25,880	582,267	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
0			25,880	582,267			
500.00	Grand Total: Decreases		1,648,400	15,412,931			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet 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	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,980,770	0	0	0	30,597	1.00	
2.00	Land Improvements	2,945,972	0	0	0	0	2.00	
3.00	Buildings and Fixtures	681,196	8,338	0	8,338	0	3.00	
4.00	Building Improvements	33,799,004	521,880	0	521,880	22,710	4.00	
5.00	Fixed Equipment	7,372,487	1,121,138	0	1,121,138	115,631	5.00	
6.00	Movable Equipment	29,661,880	1,111,609	0	1,111,609	362,235	6.00	
7.00	HIT designated Assets	6,088,014	19,069	0	19,069	22,105	7.00	
8.00	Subtotal (sum of lines 1-7)	83,529,323	2,782,034	0	2,782,034	553,278	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	83,529,323	2,782,034	0	2,782,034	553,278	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,950,173	0				1.00	
2.00	Land Improvements	2,945,972	0				2.00	
3.00	Buildings and Fixtures	689,534	0				3.00	
4.00	Building Improvements	34,298,174	0				4.00	
5.00	Fixed Equipment	8,377,994	0				5.00	
6.00	Movable Equipment	30,411,254	0				6.00	
7.00	HIT designated Assets	6,084,978	0				7.00	
8.00	Subtotal (sum of lines 1-7)	85,758,079	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	85,758,079	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
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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	2,755,357	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,896,390	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,651,747	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	2,755,357				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,896,390				2.00
3.00	Total (sum of lines 1-2)	0	5,651,747				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet 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	40,883,852	0	40,883,852	0.476735	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	44,874,226	0	44,874,226	0.523265	0	2.00
3.00	Total (sum of lines 1-2)	85,758,078	0	85,758,078	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	1,858,016	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,838,388	1,134,158	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,696,404	1,134,158	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	194,299	1,094,204	0	3,146,519	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,820	0	0	3,984,366	2.00
3.00	Total (sum of lines 1-2)	0	206,119	1,094,204	0	7,130,885	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
8/28/2020 3:07 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	2.00	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)	B	-372,608	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-44,771	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-12,549	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,022,079			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	-2,169,417			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-260,976	CAFETERIA	11.00	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	B	-20	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-184	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	B	-4,158	ADMINISTRATIVE & GENERAL	5.00	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	A	-692,551	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-88,538	CAP REL COSTS-MVBLE EQUIP	2.00	9	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	OCCUPATIONAL THERAPY	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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INSERVICE	B	0	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
8/28/2020 3:07 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 PATIENT TRANSPORTATION	A	-2,295	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 MISC NON-PATIENT REV	B		ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 OTHER MISC REVENUE	B	-48,201	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.05 PATIENT PHONES WAGE COST	A	-28,376	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 PATIENT PHONES BENEFIT COST	A	-6,982	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07 PATIENT PHONES DEPRECIATION EXPENSE	A	-6,112	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08 PATIENT TV DEPRECIATION	A	-6,754	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09 MARKETING EXPENSE	A	-275,677	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.11 PHYSICIAN RECRUITING	A	-373,011	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 LOBBYING EXPENSES	A	-10,296	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 CHARITABLE CONTRIBUTIONS	A	-150	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 SPECIAL EVENTS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15 ILLINOIS PROVIDER TAX	A	-9,850,696	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.17 NON ALLOWABLE LEGAL FEES	A	-3,573	ADMINISTRATIVE & GENERAL	5.00	0	33.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-24,279,974				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
8/28/2020 3:07 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	11,830	0 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	823,119	0 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	167,818	0 3.00
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	43,402	0 4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	2,035,152	0 4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	480,313	-661,076 4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	6,392,127 4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,561,634	5,731,051	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
				Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	QHC, INC.	100.00	QHC, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
8/28/2020 3:07 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

1.00	11,830	0		1.00
2.00	823,119	0		2.00
3.00	167,818	9		3.00
4.00	43,402	9		4.00
4.01	2,035,152	0		4.01
4.02	1,141,389	0		4.02
4.03	-6,392,127	0		4.03
5.00	-2,169,417			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOSPITAL MANAGEMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-2

Date/Time Prepared:
8/28/2020 3:07 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	52.00	DELIVERY ROOM & LABOR ROOM	334,078	334,078	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,778,321	2,778,321	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	1,384,945	1,384,945	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	234,453	234,453	0	0	0	4.00
5.00	43.00	NURSERY	140,936	140,936	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,450,531	1,450,531	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	210,878	210,878	0	0	0	7.00
8.00	60.00	LABORATORY	18,274	18,274	0	0	0	8.00
9.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	64,085	64,085	0	0	0	9.00
10.00	91.00	EMERGENCY	3,405,578	3,405,578	0	0	0	10.00
200.00			10,022,079	10,022,079	0	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	52.00	DELIVERY ROOM & LABOR ROOM	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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	43.00	NURSERY	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
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	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	334,078		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,778,321		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,384,945		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	234,453		4.00
5.00	43.00	NURSERY	0	0	0	140,936		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	1,450,531		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	210,878		7.00
8.00	60.00	LABORATORY	0	0	0	18,274		8.00
9.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	64,085		9.00
10.00	91.00	EMERGENCY	0	0	0	3,405,578		10.00
200.00			0	0	0	10,022,079		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,146,519	3,146,519			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,984,366		3,984,366		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,913,248	11,774	17,262	5,942,284	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,429,816	350,243	513,491	16,111,485	5.00
7.00	00700	OPERATION OF PLANT	5,404,898	801,217	1,174,670	7,550,403	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	310,971	19,432	28,489	358,892	8.00
9.00	00900	HOUSEKEEPING	1,778,134	29,016	42,540	1,849,690	9.00
10.00	01000	DIETARY	949,751	43,078	63,157	1,055,986	10.00
11.00	01100	CAFETERIA	782,860	31,896	46,763	861,519	11.00
13.00	01300	NURSING ADMINISTRATION	3,144,419	1,170	1,715	3,614,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	393,802	35,339	51,810	517,712	14.00
15.00	01500	PHARMACY	1,653,133	25,198	36,942	1,959,575	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,441,886	100,714	147,656	1,788,695	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,352,041	366,707	537,628	11,621,476	30.00
31.00	03100	INTENSIVE CARE UNIT	1,435,530	111,411	163,340	1,874,742	31.00
40.00	04000	SUBPROVIDER - IPF	1,528,298	57,939	84,945	1,921,019	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	784,047	4,596	6,739	822,530	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,699,564	184,711	270,805	5,438,665	50.00
51.00	05100	RECOVERY ROOM	268,730	7,972	11,687	322,299	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,690	31,721	46,507	596,225	52.00
53.00	05300	ANESTHESIOLOGY	95,849	2,535	3,717	102,101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,435,091	132,229	193,861	4,135,379	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	4,943,061	44,944	65,892	5,541,289	60.00
65.00	06500	RESPIRATORY THERAPY	798,660	36,787	53,933	1,005,996	65.00
66.00	06600	PHYSICAL THERAPY	1,079,413	86,785	127,236	1,463,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,966,021	25,363	37,184	2,172,794	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	202,186	0	0	202,186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,388,953	0	0	3,388,953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,145,039	0	0	1,145,039	73.00
74.00	07400	RENAL DIALYSIS	184,809	0	0	184,809	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	279,765	34,597	50,722	397,728	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	45,629	17,881	26,215	96,852	76.02
76.03	03950	WOUND CARE	249,062	14,052	20,602	303,231	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,616,083	43,259	63,421	2,855,180	90.00
91.00	09100	EMERGENCY	1,693,897	51,926	76,128	2,158,203	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)	83,918,221	2,704,492	3,965,057	83,417,966	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,525	5,167	8,692	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	423,878	428,856	0	853,160	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	9,646	14,142	23,788	194.00
194.01	07951	OTHER NONREIMB - MARKETING	405,787	0	0	434,214	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	76,559	0	0	86,625	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	84,824,445	3,146,519	3,984,366	84,824,445	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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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	16,111,485					5.00
7.00	00700	OPERATION OF PLANT	1,770,381	9,320,784				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	84,151	116,518	559,561			8.00
9.00	00900	HOUSEKEEPING	433,706	173,988	0	2,457,384		9.00
10.00	01000	DIETARY	247,602	258,310	0	54,713	1,616,611	10.00
11.00	01100	CAFETERIA	202,005	191,261	0	40,511	0	11.00
13.00	01300	NURSING ADMINISTRATION	847,470	7,014	0	1,486	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	121,391	211,901	0	44,883	0	14.00
15.00	01500	PHARMACY	459,471	151,093	0	32,003	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	419,404	603,907	0	127,914	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,724,959	2,198,878	375,024	465,745	1,037,499	30.00
31.00	03100	INTENSIVE CARE UNIT	439,580	668,052	23,812	141,500	55,017	31.00
40.00	04000	SUBPROVIDER - IPF	450,431	347,421	59,528	73,587	171,603	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	192,863	27,561	0	5,838	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,275,231	1,107,581	41,669	234,597	0	50.00
51.00	05100	RECOVERY ROOM	75,550	47,800	0	10,124	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,800	190,210	0	40,288	4,549	52.00
53.00	05300	ANESTHESIOLOGY	23,940	15,202	0	3,220	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	969,643	792,882	0	167,940	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,299,294	269,495	0	57,082	0	60.00
65.00	06500	RESPIRATORY THERAPY	235,881	220,583	0	46,722	0	65.00
66.00	06600	PHYSICAL THERAPY	343,054	520,389	0	110,224	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	509,466	152,081	0	32,212	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,408	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	794,625	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	268,483	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	43,333	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	93,257	207,451	0	43,940	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	22,709	107,217	0	22,710	0	76.02
76.03	03950	WOUND CARE	71,100	84,260	0	17,847	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	669,468	259,391	0	54,942	0	90.00
91.00	09100	EMERGENCY	506,045	311,362	59,528	65,950	20,387	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)	15,781,701	9,241,808	559,561	1,895,978	1,289,055	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,038	21,134	0	4,476	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	200,045	0	0	544,679	223,865	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	5,578	57,842	0	12,251	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	101,812	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	20,311	0	0	0	103,691	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
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)	16,111,485	9,320,784	559,561	2,457,384	1,616,611	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
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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	1,295,296					11.00
13.00	01300	NURSING ADMINISTRATION	102,849	4,573,150				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,546	0	911,433			14.00
15.00	01500	PHARMACY	51,594	359,649	13,617	3,027,002		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,522	0	3,742	0	2,984,184	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	398,712	2,009,617	37,227	0	573,990	30.00
31.00	03100	INTENSIVE CARE UNIT	35,453	242,111	13,584	0	42,136	31.00
40.00	04000	SUBPROVIDER - IPF	63,856	367,798	2,004	0	80,948	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	5,748	39,965	4,070	0	5,104	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	64,989	417,480	191,835	0	300,976	50.00
51.00	05100	RECOVERY ROOM	6,286	49,788	1,829	0	35,842	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,699	184,470	1,013	0	13,768	52.00
53.00	05300	ANESTHESIOLOGY	0	0	10,357	0	56,368	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,969	0	18,943	0	241,793	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	141,757	0	65,340	0	538,743	60.00
65.00	06500	RESPIRATORY THERAPY	32,423	0	12,207	0	85,436	65.00
66.00	06600	PHYSICAL THERAPY	38,087	0	853	0	58,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	34,434	212,321	52,935	0	192,930	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	85,309	0	20,597	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	325,681	0	51,307	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,027,002	88,893	73.00
74.00	07400	RENAL DIALYSIS	0	0	1	0	13,555	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	8,778	0	3,356	0	4,636	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,710	0	205	0	15,246	76.02
76.03	03950	WOUND CARE	4,927	0	2,687	0	2,911	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	25,237	90.00
91.00	09100	EMERGENCY	101,348	689,951	63,925	0	535,662	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)	1,286,687	4,573,150	910,720	3,027,002	2,984,184	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	142	0	0	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	5,635	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	2,832	0	713	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
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)	1,295,296	4,573,150	911,433	3,027,002	2,984,184	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,443,127	0	21,443,127	30.00
31.00	03100	INTENSIVE CARE UNIT	3,535,987	0	3,535,987	31.00
40.00	04000	SUBPROVIDER - IPF	3,538,195	0	3,538,195	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	1,103,679	0	1,103,679	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,073,023	0	9,073,023	50.00
51.00	05100	RECOVERY ROOM	549,428	0	549,428	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,207,022	0	1,207,022	52.00
53.00	05300	ANESTHESIOLOGY	211,188	0	211,188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,425,549	0	6,425,549	54.00
54.01	05401	ULTRA-SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	7,913,000	0	7,913,000	60.00
65.00	06500	RESPIRATORY THERAPY	1,639,248	0	1,639,248	65.00
66.00	06600	PHYSICAL THERAPY	2,533,785	0	2,533,785	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,359,173	0	3,359,173	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	355,500	0	355,500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,560,566	0	4,560,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,529,417	0	4,529,417	73.00
74.00	07400	RENAL DIALYSIS	241,698	0	241,698	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	759,146	0	759,146	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	268,649	0	268,649	76.02
76.03	03950	WOUND CARE	486,963	0	486,963	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,864,218	0	3,864,218	90.00
91.00	09100	EMERGENCY	4,512,361	0	4,512,361	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)	82,110,922	0	82,110,922	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,340	0	36,340	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,821,891	0	1,821,891	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	99,459	0	99,459	194.00
194.01	07951	OTHER NONREIMB - MARKETING	541,661	0	541,661	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	214,172	0	214,172	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	84,824,445	0	84,824,445	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
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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	11,774	17,262	29,036	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	350,243	513,491	863,734	5.00
7.00	00700	OPERATION OF PLANT	0	801,217	1,174,670	1,975,887	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,432	28,489	47,921	8.00
9.00	00900	HOUSEKEEPING	0	29,016	42,540	71,556	9.00
10.00	01000	DIETARY	0	43,078	63,157	106,235	10.00
11.00	01100	CAFETERIA	0	31,896	46,763	78,659	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,170	1,715	2,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,339	51,810	87,149	14.00
15.00	01500	PHARMACY	0	25,198	36,942	62,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	100,714	147,656	248,370	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	366,707	537,628	904,335	30.00
31.00	03100	INTENSIVE CARE UNIT	0	111,411	163,340	274,751	31.00
40.00	04000	SUBPROVIDER - IPF	0	57,939	84,945	142,884	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	4,596	6,739	11,335	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	184,711	270,805	455,516	50.00
51.00	05100	RECOVERY ROOM	0	7,972	11,687	19,659	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,721	46,507	78,228	52.00
53.00	05300	ANESTHESIOLOGY	0	2,535	3,717	6,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	132,229	193,861	326,090	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	44,944	65,892	110,836	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,787	53,933	90,720	65.00
66.00	06600	PHYSICAL THERAPY	0	86,785	127,236	214,021	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,363	37,184	62,547	69.00
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	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	34,597	50,722	85,319	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	17,881	26,215	44,096	76.02
76.03	03950	WOUND CARE	0	14,052	20,602	34,654	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	43,259	63,421	106,680	90.00
91.00	09100	EMERGENCY	0	51,926	76,128	128,054	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	2,704,492	3,965,057	6,669,549	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,525	5,167	8,692	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	428,856	0	428,856	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	9,646	14,142	23,788	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,146,519	3,984,366	7,130,885	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

Period:
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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	867,732					5.00
7.00	00700	OPERATION OF PLANT	95,346	2,072,062				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,532	25,902	78,355			8.00
9.00	00900	HOUSEKEEPING	23,358	38,679	0	133,593		9.00
10.00	01000	DIETARY	13,335	57,424	0	2,974	179,968	10.00
11.00	01100	CAFETERIA	10,879	42,518	0	2,202	0	11.00
13.00	01300	NURSING ADMINISTRATION	45,642	1,559	0	81	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,538	47,107	0	2,440	0	14.00
15.00	01500	PHARMACY	24,746	33,589	0	1,740	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,588	134,252	0	6,954	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	146,779	488,822	52,514	25,320	115,498	30.00
31.00	03100	INTENSIVE CARE UNIT	23,674	148,512	3,334	7,693	6,125	31.00
40.00	04000	SUBPROVIDER - IPF	24,259	77,234	8,336	4,000	19,104	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	10,387	6,127	0	317	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	68,679	246,221	5,835	12,754	0	50.00
51.00	05100	RECOVERY ROOM	4,069	10,626	0	550	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,529	42,285	0	2,190	506	52.00
53.00	05300	ANESTHESIOLOGY	1,289	3,379	0	175	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,222	176,262	0	9,130	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	69,975	59,910	0	3,103	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,704	49,037	0	2,540	0	65.00
66.00	06600	PHYSICAL THERAPY	18,476	115,685	0	5,992	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	27,438	33,809	0	1,751	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,553	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,796	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,460	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,334	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	5,023	46,118	0	2,389	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,223	23,835	0	1,235	0	76.02
76.03	03950	WOUND CARE	3,829	18,731	0	970	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	36,055	57,664	0	2,987	0	90.00
91.00	09100	EMERGENCY	27,254	69,218	8,336	3,585	2,270	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)	849,971	2,054,505	78,355	103,072	143,503	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	110	4,698	0	243	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,774	0	0	29,612	24,922	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	300	12,859	0	666	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	5,483	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	1,094	0	0	0	11,543	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
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)	867,732	2,072,062	78,355	133,593	179,968	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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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	134,258					11.00
13.00	01300	NURSING ADMINISTRATION	10,660	63,110				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,611	0	145,025			14.00
15.00	01500	PHARMACY	5,348	4,963	2,167	135,887		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,200	0	595	0	417,440	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,325	27,735	5,923	0	80,024	30.00
31.00	03100	INTENSIVE CARE UNIT	3,675	3,341	2,161	0	5,899	31.00
40.00	04000	SUBPROVIDER - IPF	6,619	5,075	319	0	11,332	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	596	551	648	0	714	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,736	5,761	30,524	0	42,135	50.00
51.00	05100	RECOVERY ROOM	652	687	291	0	5,018	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,804	2,546	161	0	1,927	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,648	0	7,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,258	0	3,014	0	33,850	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	14,693	0	10,397	0	75,421	60.00
65.00	06500	RESPIRATORY THERAPY	3,361	0	1,942	0	11,961	65.00
66.00	06600	PHYSICAL THERAPY	3,948	0	136	0	8,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,569	2,930	8,423	0	27,009	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,574	0	2,884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	51,824	0	7,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	135,887	12,445	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,898	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	910	0	534	0	649	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	384	0	33	0	2,134	76.02
76.03	03950	WOUND CARE	511	0	427	0	408	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	3,533	90.00
91.00	09100	EMERGENCY	10,505	9,521	10,171	0	74,990	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)	133,365	63,110	144,912	135,887	417,440	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15	0	0	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	584	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	294	0	113	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
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)	134,258	63,110	145,025	135,887	417,440	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,894,937	0	1,894,937	30.00
31.00	03100	INTENSIVE CARE UNIT	479,969	0	479,969	31.00
40.00	04000	SUBPROVIDER - IPF	300,383	0	300,383	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	30,808	0	30,808	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	875,547	0	875,547	50.00
51.00	05100	RECOVERY ROOM	41,717	0	41,717	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,789	0	139,789	52.00
53.00	05300	ANESTHESIOLOGY	20,634	0	20,634	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	612,655	0	612,655	54.00
54.01	05401	ULTRA-SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	346,718	0	346,718	60.00
65.00	06500	RESPIRATORY THERAPY	172,835	0	172,835	65.00
66.00	06600	PHYSICAL THERAPY	367,222	0	367,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	168,181	0	168,181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,011	0	19,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,803	0	101,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,792	0	162,792	73.00
74.00	07400	RENAL DIALYSIS	4,232	0	4,232	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	141,102	0	141,102	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,975	0	72,975	76.02
76.03	03950	WOUND CARE	59,625	0	59,625	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	207,566	0	207,566	90.00
91.00	09100	EMERGENCY	345,548	0	345,548	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)	6,566,049	0	6,566,049	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,743	0	13,743	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	494,181	0	494,181	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	37,613	0	37,613	194.00
194.01	07951	OTHER NONREIMB - MARKETING	6,206	0	6,206	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	13,093	0	13,093	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,130,885	0	7,130,885	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/28/2020 3:07 pm

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	610,630					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		527,404				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,285	2,285	33,235,896			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,970	67,970	4,574,809	-16,111,485	68,712,960	5.00
7.00	00700	OPERATION OF PLANT	155,489	155,489	948,695	0	7,550,403	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,771	3,771	0	0	358,892	8.00
9.00	00900	HOUSEKEEPING	5,631	5,631	0	0	1,849,690	9.00
10.00	01000	DIETARY	8,360	8,360	0	0	1,055,986	10.00
11.00	01100	CAFETERIA	6,190	6,190	0	0	861,519	11.00
13.00	01300	NURSING ADMINISTRATION	227	227	2,612,138	0	3,614,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,858	6,858	205,610	0	517,712	14.00
15.00	01500	PHARMACY	4,890	4,890	1,366,411	0	1,959,575	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,545	19,545	550,580	0	1,788,695	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	71,165	71,165	7,635,139	0	11,621,476	30.00
31.00	03100	INTENSIVE CARE UNIT	21,621	21,621	919,852	0	1,874,742	31.00
40.00	04000	SUBPROVIDER - IPF	11,244	11,244	1,397,371	0	1,921,019	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	892	892	151,840	0	822,530	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,846	35,846	1,586,128	0	5,438,665	50.00
51.00	05100	RECOVERY ROOM	1,547	1,547	189,161	0	322,209	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,156	6,156	700,858	0	596,225	52.00
53.00	05300	ANESTHESIOLOGY	492	492	0	0	102,101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,661	25,661	2,092,936	0	4,135,379	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	8,722	8,722	2,726,045	0	5,541,289	60.00
65.00	06500	RESPIRATORY THERAPY	7,139	7,139	652,246	0	1,005,996	65.00
66.00	06600	PHYSICAL THERAPY	16,842	16,842	948,808	0	1,463,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,922	4,922	806,671	0	2,172,794	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	202,186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,388,953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,145,039	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	184,809	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	6,714	6,714	182,581	0	397,728	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	3,470	39,864	0	96,852	76.02
76.03	03950	WOUND CARE	2,727	2,727	109,148	0	303,231	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,395	8,395	740,624	0	2,855,180	90.00
91.00	09100	EMERGENCY	10,077	10,077	1,880,700	0	2,158,203	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)	524,848	524,848	33,018,215	-16,111,485	67,306,481	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	684	0	0	8,692	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	83,226	0	2,382	0	853,160	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	1,872	1,872	0	0	23,788	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	158,998	0	434,214	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	56,301	0	86,625	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
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)	3,146,519	3,984,366	5,942,284		16,111,485	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.152906	7.554675	0.178791		0.234475	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			29,036		867,732	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000874		0.012628	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

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	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			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	301,660					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,771	456,501				8.00
9.00	00900	HOUSEKEEPING	5,631	0	375,484			9.00
10.00	01000	DIETARY	8,360	0	8,360	137,899		10.00
11.00	01100	CAFETERIA	6,190	0	6,190	0	45,742	11.00
13.00	01300	NURSING ADMINISTRATION	227	0	227	0	3,632	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,858	0	6,858	0	549	14.00
15.00	01500	PHARMACY	4,890	0	4,890	0	1,822	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,545	0	19,545	0	1,431	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	71,165	305,953	71,165	88,500	14,080	30.00
31.00	03100	INTENSIVE CARE UNIT	21,621	19,426	21,621	4,693	1,252	31.00
40.00	04000	SUBPROVIDER - IPF	11,244	48,564	11,244	14,638	2,255	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	892	0	892	0	203	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,846	33,994	35,846	0	2,295	50.00
51.00	05100	RECOVERY ROOM	1,547	0	1,547	0	222	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,156	0	6,156	388	1,296	52.00
53.00	05300	ANESTHESIOLOGY	492	0	492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,661	0	25,661	0	3,495	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	8,722	0	8,722	0	5,006	60.00
65.00	06500	RESPIRATORY THERAPY	7,139	0	7,139	0	1,145	65.00
66.00	06600	PHYSICAL THERAPY	16,842	0	16,842	0	1,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,922	0	4,922	0	1,216	69.00
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	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	6,714	0	6,714	0	310	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	0	3,470	0	131	76.02
76.03	03950	WOUND CARE	2,727	0	2,727	0	174	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,395	0	8,395	0	0	90.00
91.00	09100	EMERGENCY	10,077	48,564	10,077	1,739	3,579	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)	299,104	456,501	289,702	109,958	45,438	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	0	684	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	83,226	19,096	5	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	1,872	0	1,872	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	0	199	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	8,845	100	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
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)	9,320,784	559,561	2,457,384	1,616,611	1,295,296	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.898309	1.225761	6.544577	11.723152	28.317433	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,072,062	78,355	133,593	179,968	134,258	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.868866	0.171643	0.355789	1.305071	2.935114	205.00
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: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQ S)	PHARMACY (COSTED REQ S)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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					11.00
13.00	01300	NURSING ADMINISTRATION	17,374,755				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,006,587			14.00
15.00	01500	PHARMACY	1,366,411	104,679	1,145,059		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,770	0	854,311,276	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,635,140	286,179	0	164,303,957	30.00
31.00	03100	INTENSIVE CARE UNIT	919,852	104,423	0	12,062,894	31.00
40.00	04000	SUBPROVIDER - IPF	1,397,371	15,407	0	23,174,359	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	151,840	31,290	0	1,461,086	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,586,128	1,474,721	0	86,165,591	50.00
51.00	05100	RECOVERY ROOM	189,161	14,064	0	10,261,160	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	700,857	7,787	0	3,941,665	52.00
53.00	05300	ANESTHESIOLOGY	0	79,620	0	16,137,476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	145,622	0	69,222,221	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	502,300	0	154,235,026	60.00
65.00	06500	RESPIRATORY THERAPY	0	93,844	0	24,459,109	65.00
66.00	06600	PHYSICAL THERAPY	0	6,560	0	16,635,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	806,671	406,932	0	55,233,296	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	655,811	0	5,896,736	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,503,640	0	14,688,528	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,145,059	25,448,964	73.00
74.00	07400	RENAL DIALYSIS	0	4	0	3,880,579	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	25,797	0	1,327,357	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,579	0	4,364,741	76.02
76.03	03950	WOUND CARE	0	20,654	0	833,402	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	7,225,061	90.00
91.00	09100	EMERGENCY	2,621,324	491,422	0	153,353,009	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)	17,374,755	7,001,105	1,145,059	854,311,276	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	5,482	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
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)	4,573,150	911,433	3,027,002	2,984,184	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.263207	0.130082	2.643534	0.003493	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	63,110	145,025	135,887	417,440	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003632	0.020698	0.118672	0.000489	205.00
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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 3:07 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	21,443,127		21,443,127	0	21,443,127	30.00
31.00	03100	INTENSIVE CARE UNIT	3,535,987		3,535,987	0	3,535,987	31.00
40.00	04000	SUBPROVIDER - IPF	3,538,195		3,538,195	0	3,538,195	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	1,103,679		1,103,679	0	1,103,679	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,073,023		9,073,023	0	9,073,023	50.00
51.00	05100	RECOVERY ROOM	549,428		549,428	0	549,428	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,207,022		1,207,022	0	1,207,022	52.00
53.00	05300	ANESTHESIOLOGY	211,188		211,188	0	211,188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,425,549		6,425,549	0	6,425,549	54.00
54.01	05401	ULTRA-SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	7,913,000		7,913,000	0	7,913,000	60.00
65.00	06500	RESPIRATORY THERAPY	1,639,248	0	1,639,248	0	1,639,248	65.00
66.00	06600	PHYSICAL THERAPY	2,533,785	0	2,533,785	0	2,533,785	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,359,173		3,359,173	0	3,359,173	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	355,500		355,500	0	355,500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,560,566		4,560,566	0	4,560,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,529,417		4,529,417	0	4,529,417	73.00
74.00	07400	RENAL DIALYSIS	241,698		241,698	0	241,698	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	759,146		759,146	0	759,146	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	268,649		268,649	0	268,649	76.02
76.03	03950	WOUND CARE	486,963		486,963	0	486,963	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,864,218		3,864,218	0	3,864,218	90.00
91.00	09100	EMERGENCY	4,512,361		4,512,361	0	4,512,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,706,463		1,706,463	0	1,706,463	92.00
200.00		Subtotal (see instructions)	83,817,385	0	83,817,385	0	83,817,385	200.00
201.00		Less Observation Beds	1,706,463		1,706,463	0	1,706,463	201.00
202.00		Total (see instructions)	82,110,922	0	82,110,922	0	82,110,922	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 3:07 pm

			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	154,669,206		154,669,206			30.00	
31.00	03100	INTENSIVE CARE UNIT	12,062,894		12,062,894			31.00	
40.00	04000	SUBPROVIDER - IPF	23,174,359		23,174,359			40.00	
41.00	04100	SUBPROVIDER - IRF	0		0			41.00	
43.00	04300	NURSERY	1,461,086		1,461,086			43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,229,961	62,935,630	86,165,591	0.105298	0.000000	50.00	
51.00	05100	RECOVERY ROOM	2,667,808	7,593,352	10,261,160	0.053544	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,913,041	28,624	3,941,665	0.306221	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	4,946,653	11,190,823	16,137,476	0.013087	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,626,511	57,595,710	69,222,221	0.092825	0.000000	54.00	
54.01	05401	ULTRA-SOUND	0	0	0	0.000000	0.000000	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
60.00	06000	LABORATORY	50,102,144	104,132,882	154,235,026	0.051305	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	19,122,254	5,336,855	24,459,109	0.067020	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,027,415	13,607,644	16,635,059	0.152316	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	24,246,430	30,986,866	55,233,296	0.060818	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,416,801	479,935	5,896,736	0.060288	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,623,351	9,065,177	14,688,528	0.310485	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	16,211,478	9,237,486	25,448,964	0.177980	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	3,506,300	374,279	3,880,579	0.062284	0.000000	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00	
76.01	03610	SLEEP LAB	0	1,327,357	1,327,357	0.571923	0.000000	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,091,487	273,254	4,364,741	0.061550	0.000000	76.02	
76.03	03950	WOUND CARE	1,428	831,974	833,402	0.584307	0.000000	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,223	7,222,838	7,225,061	0.534835	0.000000	90.00	
91.00	09100	EMERGENCY	37,916,853	115,436,156	153,353,009	0.029425	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,343,316	6,291,435	9,634,751	0.177115	0.000000	92.00	
200.00		Subtotal (see instructions)	410,362,999	443,948,277	854,311,276			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	410,362,999	443,948,277	854,311,276			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 3:07 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
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.105298			50.00
51.00	05100	RECOVERY ROOM	0.053544			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.306221			52.00
53.00	05300	ANESTHESIOLOGY	0.013087			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092825			54.00
54.01	05401	ULTRA-SOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.051305			60.00
65.00	06500	RESPIRATORY THERAPY	0.067020			65.00
66.00	06600	PHYSICAL THERAPY	0.152316			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.060818			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.060288			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.310485			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177980			73.00
74.00	07400	RENAL DIALYSIS	0.062284			74.00
76.00	03020	ACUPUNCTURE	0.000000			76.00
76.01	03610	SLEEP LAB	0.571923			76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.061550			76.02
76.03	03950	WOUND CARE	0.584307			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.534835			90.00
91.00	09100	EMERGENCY	0.029425			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.177115			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 3:07 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,443,127		21,443,127	0	21,443,127	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,535,987		3,535,987	0	3,535,987	31.00	
40.00	04000	SUBPROVIDER - IPF	3,538,195		3,538,195	0	3,538,195	40.00	
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00	
43.00	04300	NURSERY	1,103,679		1,103,679	0	1,103,679	43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,073,023		9,073,023	0	9,073,023	50.00	
51.00	05100	RECOVERY ROOM	549,428		549,428	0	549,428	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,207,022		1,207,022	0	1,207,022	52.00	
53.00	05300	ANESTHESIOLOGY	211,188		211,188	0	211,188	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,425,549		6,425,549	0	6,425,549	54.00	
54.01	05401	ULTRA-SOUND	0		0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00	
57.00	05700	CT SCAN	0		0	0	0	57.00	
58.00	05800	MRI	0		0	0	0	58.00	
60.00	06000	LABORATORY	7,913,000		7,913,000	0	7,913,000	60.00	
65.00	06500	RESPIRATORY THERAPY	1,639,248	0	1,639,248	0	1,639,248	65.00	
66.00	06600	PHYSICAL THERAPY	2,533,785	0	2,533,785	0	2,533,785	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	3,359,173		3,359,173	0	3,359,173	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	355,500		355,500	0	355,500	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,560,566		4,560,566	0	4,560,566	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,529,417		4,529,417	0	4,529,417	73.00	
74.00	07400	RENAL DIALYSIS	241,698		241,698	0	241,698	74.00	
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00	
76.01	03610	SLEEP LAB	759,146		759,146	0	759,146	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	268,649		268,649	0	268,649	76.02	
76.03	03950	WOUND CARE	486,963		486,963	0	486,963	76.03	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,864,218		3,864,218	0	3,864,218	90.00	
91.00	09100	EMERGENCY	4,512,361		4,512,361	0	4,512,361	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,706,463		1,706,463	0	1,706,463	92.00	
200.00		Subtotal (see instructions)	83,817,385	0	83,817,385	0	83,817,385	200.00	
201.00		Less Observation Beds	1,706,463		1,706,463	0	1,706,463	201.00	
202.00		Total (see instructions)	82,110,922	0	82,110,922	0	82,110,922	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 3:07 pm

			Title XIX			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	154,669,206		154,669,206			30.00	
31.00	03100	INTENSIVE CARE UNIT	12,062,894		12,062,894			31.00	
40.00	04000	SUBPROVIDER - IPF	23,174,359		23,174,359			40.00	
41.00	04100	SUBPROVIDER - IRF	0		0			41.00	
43.00	04300	NURSERY	1,461,086		1,461,086			43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,229,961	62,935,630	86,165,591	0.105298	0.000000	50.00	
51.00	05100	RECOVERY ROOM	2,667,808	7,593,352	10,261,160	0.053544	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,913,041	28,624	3,941,665	0.306221	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	4,946,653	11,190,823	16,137,476	0.013087	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,626,511	57,595,710	69,222,221	0.092825	0.000000	54.00	
54.01	05401	ULTRA-SOUND	0	0	0	0.000000	0.000000	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
60.00	06000	LABORATORY	50,102,144	104,132,882	154,235,026	0.051305	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	19,122,254	5,336,855	24,459,109	0.067020	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,027,415	13,607,644	16,635,059	0.152316	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	24,246,430	30,986,866	55,233,296	0.060818	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,416,801	479,935	5,896,736	0.060288	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,623,351	9,065,177	14,688,528	0.310485	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	16,211,478	9,237,486	25,448,964	0.177980	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	3,506,300	374,279	3,880,579	0.062284	0.000000	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00	
76.01	03610	SLEEP LAB	0	1,327,357	1,327,357	0.571923	0.000000	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,091,487	273,254	4,364,741	0.061550	0.000000	76.02	
76.03	03950	WOUND CARE	1,428	831,974	833,402	0.584307	0.000000	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,223	7,222,838	7,225,061	0.534835	0.000000	90.00	
91.00	09100	EMERGENCY	37,916,853	115,436,156	153,353,009	0.029425	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,343,316	6,291,435	9,634,751	0.177115	0.000000	92.00	
200.00		Subtotal (see instructions)	410,362,999	443,948,277	854,311,276			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	410,362,999	443,948,277	854,311,276			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/28/2020 3:07 pm
			Title XIX	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.105298		50.00
51.00	05100	RECOVERY ROOM	0.053544		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.306221		52.00
53.00	05300	ANESTHESIOLOGY	0.013087		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092825		54.00
54.01	05401	ULTRA-SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.051305		60.00
65.00	06500	RESPIRATORY THERAPY	0.067020		65.00
66.00	06600	PHYSICAL THERAPY	0.152316		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.060818		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.060288		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.310485		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177980		73.00
74.00	07400	RENAL DIALYSIS	0.062284		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.571923		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.061550		76.02
76.03	03950	WOUND CARE	0.584307		76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.534835		90.00
91.00	09100	EMERGENCY	0.029425		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.177115		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet C
Part II
Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,073,023	875,547	8,197,476	0	0
51.00	05100	RECOVERY ROOM	549,428	41,717	507,711	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,207,022	139,789	1,067,233	0	0
53.00	05300	ANESTHESIOLOGY	211,188	20,634	190,554	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,425,549	612,655	5,812,894	0	0
54.01	05401	ULTRA-SOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	7,913,000	346,718	7,566,282	0	0
65.00	06500	RESPIRATORY THERAPY	1,639,248	172,835	1,466,413	0	0
66.00	06600	PHYSICAL THERAPY	2,533,785	367,222	2,166,563	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	3,359,173	168,181	3,190,992	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	355,500	19,011	336,489	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,560,566	101,803	4,458,763	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,529,417	162,792	4,366,625	0	0
74.00	07400	RENAL DIALYSIS	241,698	4,232	237,466	0	0
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	759,146	141,102	618,044	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	268,649	72,975	195,674	0	0
76.03	03950	WOUND CARE	486,963	59,625	427,338	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,864,218	207,566	3,656,652	0	0
91.00	09100	EMERGENCY	4,512,361	345,548	4,166,813	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,706,463	150,800	1,555,663	0	0
200.00		Subtotal (sum of lines 50 thru 199)	54,196,397	4,010,752	50,185,645	0	0
201.00		Less Observation Beds	1,706,463	150,800	1,555,663	0	0
202.00		Total (line 200 minus line 201)	52,489,934	3,859,952	48,629,982	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet C
Part II
Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,073,023	86,165,591	0.105298	50.00
51.00	05100	RECOVERY ROOM	549,428	10,261,160	0.053544	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,207,022	3,941,665	0.306221	52.00
53.00	05300	ANESTHESIOLOGY	211,188	16,137,476	0.013087	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,425,549	69,222,221	0.092825	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	7,913,000	154,235,026	0.051305	60.00
65.00	06500	RESPIRATORY THERAPY	1,639,248	24,459,109	0.067020	65.00
66.00	06600	PHYSICAL THERAPY	2,533,785	16,635,059	0.152316	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,359,173	55,233,296	0.060818	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	355,500	5,896,736	0.060288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,560,566	14,688,528	0.310485	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,529,417	25,448,964	0.177980	73.00
74.00	07400	RENAL DIALYSIS	241,698	3,880,579	0.062284	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	759,146	1,327,357	0.571923	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	268,649	4,364,741	0.061550	76.02
76.03	03950	WOUND CARE	486,963	833,402	0.584307	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,864,218	7,225,061	0.534835	90.00
91.00	09100	EMERGENCY	4,512,361	153,353,009	0.029425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,706,463	9,634,751	0.177115	92.00
200.00		Subtotal (sum of lines 50 thru 199)	54,196,397	662,943,731		200.00
201.00		Less Observation Beds	1,706,463	0		201.00
202.00		Total (line 200 minus line 201)	52,489,934	662,943,731		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/28/2020 3:07 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	1,894,937	0	1,894,937	27,871	67.99	30.00
31.00	INTENSIVE CARE UNIT	479,969		479,969	1,236	388.32	31.00
40.00	SUBPROVIDER - IPF	300,383	0	300,383	4,128	72.77	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	30,808		30,808	521	59.13	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,706,097		2,706,097	33,756		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	5,384	366,058				30.00
31.00	INTENSIVE CARE UNIT	488	189,500				31.00
40.00	SUBPROVIDER - IPF	1,939	141,101				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	7,811	696,659				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/28/2020 3:07 pm		
				Title XVIII		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	875,547	86,165,591	0.010161	7,106,938	72,214	50.00
51.00	05100	RECOVERY ROOM	41,717	10,261,160	0.004066	607,958	2,472	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,789	3,941,665	0.035464	2,185	77	52.00
53.00	05300	ANESTHESIOLOGY	20,634	16,137,476	0.001279	1,456,006	1,862	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	612,655	69,222,221	0.008851	4,431,933	39,227	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	346,718	154,235,026	0.002248	15,125,608	34,002	60.00
65.00	06500	RESPIRATORY THERAPY	172,835	24,459,109	0.007066	8,924,144	63,058	65.00
66.00	06600	PHYSICAL THERAPY	367,222	16,635,059	0.022075	1,324,284	29,234	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	168,181	55,233,296	0.003045	8,518,812	25,940	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,011	5,896,736	0.003224	2,564,408	8,268	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,803	14,688,528	0.006931	1,906,988	13,217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,792	25,448,964	0.006397	4,916,225	31,449	73.00
74.00	07400	RENAL DIALYSIS	4,232	3,880,579	0.001091	2,043,367	2,229	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	141,102	1,327,357	0.106303	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,975	4,364,741	0.016719	353,305	5,907	76.02
76.03	03950	WOUND CARE	59,625	833,402	0.071544	633	45	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	207,566	7,225,061	0.028729	2,223	64	90.00
91.00	09100	EMERGENCY	345,548	153,353,009	0.002253	10,606,458	23,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	150,800	9,634,751	0.015652	1,409,436	22,060	92.00
200.00		Total (lines 50 through 199)	4,010,752	662,943,731		71,300,911	375,221	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/28/2020 3:07 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	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	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	27,871	0.00	5,384		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,236	0.00	488		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	4,128	0.00	1,939		40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0		41.00		
43.00	04300	NURSERY	0	0	521	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)	0	0	33,756	0.00	7,811		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
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
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: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	86,165,591	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,261,160	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,941,665	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,137,476	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	69,222,221	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	154,235,026	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,459,109	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,635,059	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	55,233,296	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,896,736	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,688,528	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,448,964	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,880,579	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,327,357	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,364,741	0.000000	76.02
76.03	03950	WOUND CARE	0	0	0	833,402	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,225,061	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	153,353,009	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,634,751	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	662,943,731		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 3:07 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	7,106,938	0	13,057,134	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	607,958	0	1,408,312	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,185	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,456,006	0	2,427,906	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,431,933	0	10,034,054	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0.000000	15,125,608	0	7,682,756	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	8,924,144	0	1,314,141	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,324,284	0	43,054	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,518,812	0	7,237,659	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,564,408	0	133,545	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,906,988	0	3,398,883	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,916,225	0	1,493,499	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,043,367	0	173,840	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	187,856	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	353,305	0	25,884	0	76.02
76.03	03950	WOUND CARE	0.000000	633	0	342,550	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	2,223	0	179,409	0	90.00
91.00	09100	EMERGENCY	0.000000	10,606,458	0	16,272,195	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,409,436	0	1,492,101	0	92.00
200.00		Total (lines 50 through 199)		71,300,911	0	66,904,778	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/28/2020 3:07 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		0.105298	13,057,134	0	0	1,374,890	50.00
51.00	05100	RECOVERY ROOM		0.053544	1,408,312	0	0	75,407	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.306221	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.013087	2,427,906	0	0	31,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.092825	10,034,054	0	0	931,411	54.00
54.01	05401	ULTRA-SOUND		0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY		0.051305	7,682,756	0	0	394,164	60.00
65.00	06500	RESPIRATORY THERAPY		0.067020	1,314,141	0	0	88,074	65.00
66.00	06600	PHYSICAL THERAPY		0.152316	43,054	0	0	6,558	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.060818	7,237,659	0	0	440,180	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.060288	133,545	0	0	8,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.310485	3,398,883	0	0	1,055,302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.177980	1,493,499	0	26,502	265,813	73.00
74.00	07400	RENAL DIALYSIS		0.062284	173,840	0	0	10,827	74.00
76.00	03020	ACUPUNCTURE		0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0.571923	187,856	0	0	107,439	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.061550	25,884	0	0	1,593	76.02
76.03	03950	WOUND CARE		0.584307	342,550	0	0	200,154	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.534835	179,409	0	0	95,954	90.00
91.00	09100	EMERGENCY		0.029425	16,272,195	0	0	478,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.177115	1,492,101	0	0	264,273	92.00
200.00		Subtotal (see instructions)			66,904,778	0	26,502	5,830,673	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			66,904,778	0	26,502	5,830,673	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/28/2020 3:07 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRA-SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	4,717		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
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	4,717		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	4,717		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 8/28/2020 3:07 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	875,547	86,165,591	0.010161	0	0	50.00	
51.00	05100	RECOVERY ROOM	41,717	10,261,160	0.004066	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,789	3,941,665	0.035464	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	20,634	16,137,476	0.001279	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	612,655	69,222,221	0.008851	66,539	589	54.00	
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00	
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00	
58.00	05800	MRI	0	0	0.000000	0	0	58.00	
60.00	06000	LABORATORY	346,718	154,235,026	0.002248	1,044,891	2,349	60.00	
65.00	06500	RESPIRATORY THERAPY	172,835	24,459,109	0.007066	16,340	115	65.00	
66.00	06600	PHYSICAL THERAPY	367,222	16,635,059	0.022075	53,881	1,189	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	168,181	55,233,296	0.003045	20,170	61	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,011	5,896,736	0.003224	44,182	142	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,803	14,688,528	0.006931	897	6	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	162,792	25,448,964	0.006397	594,005	3,800	73.00	
74.00	07400	RENAL DIALYSIS	4,232	3,880,579	0.001091	18,499	20	74.00	
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00	
76.01	03610	SLEEP LAB	141,102	1,327,357	0.106303	0	0	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,975	4,364,741	0.016719	213,851	3,575	76.02	
76.03	03950	WOUND CARE	59,625	833,402	0.071544	0	0	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	207,566	7,225,061	0.028729	0	0	90.00	
91.00	09100	EMERGENCY	345,548	153,353,009	0.002253	856,149	1,929	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,634,751	0.000000	0	0	92.00	
200.00		Total (lines 50 through 199)	3,859,952	662,943,731		2,929,404	13,775	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 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
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
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	05401	ULTRA-SOUND		0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
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	03020	ACUPUNCTURE		0	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.02
76.03	03950	WOUND CARE		0	0	0	0	0	76.03
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: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	86,165,591	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,261,160	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,941,665	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,137,476	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	69,222,221	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	154,235,026	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,459,109	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,635,059	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	55,233,296	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,896,736	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,688,528	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,448,964	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,880,579	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,327,357	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,364,741	0.000000	76.02
76.03	03950	WOUND CARE	0	0	0	833,402	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,225,061	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	153,353,009	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,634,751	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	662,943,731		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 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
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	66,539	0	1,993	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0.000000	1,044,891	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	16,340	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	53,881	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	20,170	0	667	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	44,182	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	897	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	594,005	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	18,499	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	213,851	0	0	0	76.02
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	856,149	0	15,658	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)		2,929,404	0	18,318	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/28/2020 3:07 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.105298	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.053544	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.306221	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.013087	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092825	1,993	0	0	185	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0.051305	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.067020	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.152316	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060818	667	0	0	41	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.060288	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.310485	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177980	0	0	1,686	0	73.00
74.00	07400	RENAL DIALYSIS	0.062284	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.571923	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.061550	0	0	0	0	76.02
76.03	03950	WOUND CARE	0.584307	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.534835	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.029425	15,658	0	0	461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.177115	0	0	0	0	92.00
200.00		Subtotal (see instructions)		18,318	0	1,686	687	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
202.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		18,318	0	1,686	687	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/28/2020 3:07 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			
51.00	05100	RECOVERY ROOM	0	0	51.00			
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00			
53.00	05300	ANESTHESIOLOGY	0	0	53.00			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00			
54.01	05401	ULTRA-SOUND	0	0	54.01			
56.00	05600	RADIOISOTOPE	0	0	56.00			
57.00	05700	CT SCAN	0	0	57.00			
58.00	05800	MRI	0	0	58.00			
60.00	06000	LABORATORY	0	0	60.00			
65.00	06500	RESPIRATORY THERAPY	0	0	65.00			
66.00	06600	PHYSICAL THERAPY	0	0	66.00			
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00			
68.00	06800	SPEECH PATHOLOGY	0	0	68.00			
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00			
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	300	73.00			
74.00	07400	RENAL DIALYSIS	0	0	74.00			
76.00	03020	ACUPUNCTURE	0	0	76.00			
76.01	03610	SLEEP LAB	0	0	76.01			
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02			
76.03	03950	WOUND CARE	0	0	76.03			
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	300	200.00			
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00			
202.00		Net Charges (line 200 - line 201)	0	300	202.00			

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/28/2020 3:07 pm

			Title XIX		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	1,894,937	0	1,894,937	27,871	67.99	30.00
31.00	INTENSIVE CARE UNIT	479,969		479,969	1,236	388.32	31.00
40.00	SUBPROVIDER - IPF	300,383	0	300,383	4,128	72.77	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	30,808		30,808	521	59.13	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,706,097		2,706,097	33,756		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	4,726	321,321				30.00
31.00	INTENSIVE CARE UNIT	45	17,474				31.00
40.00	SUBPROVIDER - IPF	82	5,967				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
43.00	NURSERY	121	7,155				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	4,974	351,917				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description		Title XIX		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	875,547	86,165,591	0.010161	0	50.00
51.00	05100	RECOVERY ROOM	41,717	10,261,160	0.004066	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,789	3,941,665	0.035464	0	52.00
53.00	05300	ANESTHESIOLOGY	20,634	16,137,476	0.001279	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	612,655	69,222,221	0.008851	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0	58.00
60.00	06000	LABORATORY	346,718	154,235,026	0.002248	0	60.00
65.00	06500	RESPIRATORY THERAPY	172,835	24,459,109	0.007066	0	65.00
66.00	06600	PHYSICAL THERAPY	367,222	16,635,059	0.022075	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	168,181	55,233,296	0.003045	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,011	5,896,736	0.003224	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,803	14,688,528	0.006931	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,792	25,448,964	0.006397	0	73.00
74.00	07400	RENAL DIALYSIS	4,232	3,880,579	0.001091	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	76.00
76.01	03610	SLEEP LAB	141,102	1,327,357	0.106303	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,975	4,364,741	0.016719	0	76.02
76.03	03950	WOUND CARE	59,625	833,402	0.071544	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	207,566	7,225,061	0.028729	0	90.00
91.00	09100	EMERGENCY	345,548	153,353,009	0.002253	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	150,800	9,634,751	0.015652	0	92.00
200.00		Total (lines 50 through 199)	4,010,752	662,943,731		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/28/2020 3:07 pm		
					Title XIX		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	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	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	27,871	0.00	4,726		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,236	0.00	45		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	4,128	0.00	82		40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0		41.00		
43.00	04300	NURSERY	0	0	521	0.00	121		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)	0	0	33,756	0.00	4,974		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
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description		Title XIX		Hospital		PPS	
		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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 pm	
			Title XIX		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	86,165,591	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,261,160	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,941,665	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,137,476	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	69,222,221	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	154,235,026	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,459,109	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,635,059	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	55,233,296	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,896,736	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,688,528	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,448,964	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,880,579	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,327,357	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,364,741	0.000000	76.02
76.03	03950	WOUND CARE	0	0	0	833,402	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,225,061	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	153,353,009	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,634,751	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	662,943,731		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description		Title XIX		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	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	76.02
76.03	03950	WOUND CARE	0.000000	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 8/28/2020 3:07 pm	
				Title XIX		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		875,547	86,165,591	0.010161	0	0	50.00
51.00	05100	RECOVERY ROOM		41,717	10,261,160	0.004066	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		139,789	3,941,665	0.035464	0	0	52.00
53.00	05300	ANESTHESIOLOGY		20,634	16,137,476	0.001279	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		612,655	69,222,221	0.008851	0	0	54.00
54.01	05401	ULTRA-SOUND		0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE		0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN		0	0	0.000000	0	0	57.00
58.00	05800	MRI		0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY		346,718	154,235,026	0.002248	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		172,835	24,459,109	0.007066	0	0	65.00
66.00	06600	PHYSICAL THERAPY		367,222	16,635,059	0.022075	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		168,181	55,233,296	0.003045	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		19,011	5,896,736	0.003224	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		101,803	14,688,528	0.006931	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		162,792	25,448,964	0.006397	0	0	73.00
74.00	07400	RENAL DIALYSIS		4,232	3,880,579	0.001091	0	0	74.00
76.00	03020	ACUPUNCTURE		0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB		141,102	1,327,357	0.106303	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		72,975	4,364,741	0.016719	0	0	76.02
76.03	03950	WOUND CARE		59,625	833,402	0.071544	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		207,566	7,225,061	0.028729	0	0	90.00
91.00	09100	EMERGENCY		345,548	153,353,009	0.002253	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	9,634,751	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		3,859,952	662,943,731		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 pm	
				Title XIX		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
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
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	05401	ULTRA-SOUND		0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
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	03020	ACUPUNCTURE		0	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.02
76.03	03950	WOUND CARE		0	0	0	0	0	76.03
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: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 pm	
			Title XIX		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	86,165,591	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,261,160	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,941,665	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,137,476	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	69,222,221	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	154,235,026	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,459,109	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,635,059	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	55,233,296	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,896,736	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,688,528	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,448,964	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,880,579	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,327,357	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,364,741	0.000000	76.02
76.03	03950	WOUND CARE	0	0	0	833,402	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,225,061	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	153,353,009	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,634,751	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	662,943,731		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 3:07 pm	
				Title XIX		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
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND		0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	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	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE		0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE		0.000000	0	0	0	0	76.03
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)			0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/28/2020 3:07 pm	
			Title XIX		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	0.105298	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.053544	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.306221	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.013087	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092825	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0.051305	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.067020	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.152316	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060818	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.060288	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.310485	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177980	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.062284	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.571923	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.061550	0	0	0	0	76.02
76.03	03950	WOUND CARE	0.584307	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.534835	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.029425	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.177115	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/28/2020 3:07 pm		
			Title XIX		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
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05401	ULTRA-SOUND	0	0					54.01
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
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	03020	ACUPUNCTURE	0	0					76.00
76.01	03610	SLEEP LAB	0	0					76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0					76.02
76.03	03950	WOUND CARE	0	0					76.03
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: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 3:07 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)		27,871	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		27,871	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)		25,653	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) (see instructions)		5,384	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)		21,443,127	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)		21,443,127	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)		21,443,127	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)		769.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,142,288	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)		4,142,288	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/28/2020 3:07 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		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)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,535,987	1,236	2,860.83	488	1,396,085
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,639,924
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,178,297
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					555,558
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					375,221
52.00	Total Program excludable cost (sum of lines 50 and 51)					930,779
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,247,518
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					2,218
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					769.37
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,706,463

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/28/2020 3:07 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	1,894,937	21,443,127	0.088370	1,706,463	150,800
91.00	Nursing School cost	0	21,443,127	0.000000	1,706,463	0
92.00	Allied health cost	0	21,443,127	0.000000	1,706,463	0
93.00	All other Medical Education	0	21,443,127	0.000000	1,706,463	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 3:07 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)		4,128	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,128	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)		4,128	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) (see instructions)		1,939	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)		3,538,195	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)		3,538,195	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)		3,538,195	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)		857.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,661,956	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)		1,661,956	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 3:07 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)	0	0	0.00	0		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)					218,484	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,880,440	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)					141,101	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					13,775	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					154,876	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,725,564	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: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 3:07 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	300,383	3,538,195	0.084897	0	0 90.00
91.00	Nursing School cost	0	3,538,195	0.000000	0	0 91.00
92.00	Allied health cost	0	3,538,195	0.000000	0	0 92.00
93.00	All other Medical Education	0	3,538,195	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 3:07 pm	
		Title XIX	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)			27,871	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			27,871	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)			25,653	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) (see instructions)			4,726	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)			521	15.00
16.00	Nursery days (title V or XIX only)			121	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)			21,443,127	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)			21,443,127	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)			21,443,127	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)			769.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,636,043	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)			3,636,043	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description		Title XIX		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)	1,103,679	521	2,118.39	121	256,325	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,535,987	1,236	2,860.83	45	128,737	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,021,105	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)					345,950	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					345,950	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,675,155	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)					2,218	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					769.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,706,463	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description		Title XIX		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	1,894,937	21,443,127	0.088370	1,706,463	150,800
91.00	Nursing School cost	0	21,443,127	0.000000	1,706,463	0
92.00	Allied health cost	0	21,443,127	0.000000	1,706,463	0
93.00	All other Medical Education	0	21,443,127	0.000000	1,706,463	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 3:07 pm
		Title XIX	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)		4,128	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,128	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)		4,128	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) (see instructions)		82	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)		521	15.00
16.00	Nursery days (title V or XIX only)		121	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)		3,538,195	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)		3,538,195	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)		3,538,195	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)		857.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		70,284	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)		70,284	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 3:07 pm	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		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)	0	0	0.00	0		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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					70,284	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)					5,967	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,967	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					64,317	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: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 3:07 pm	
		Title XIX		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	300,383	3,538,195	0.084897	0	0 90.00
91.00	Nursing School cost	0	3,538,195	0.000000	0	0 91.00
92.00	Allied health cost	0	3,538,195	0.000000	0	0 92.00
93.00	All other Medical Education	0	3,538,195	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/28/2020 3:07 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		32,170,204	30.00
31.00	03100	INTENSIVE CARE UNIT		4,756,666	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.105298	7,106,938	748,346 50.00
51.00	05100	RECOVERY ROOM	0.053544	607,958	32,553 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.306221	2,185	669 52.00
53.00	05300	ANESTHESIOLOGY	0.013087	1,456,006	19,055 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092825	4,431,933	411,394 54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
60.00	06000	LABORATORY	0.051305	15,125,608	776,019 60.00
65.00	06500	RESPIRATORY THERAPY	0.067020	8,924,144	598,096 65.00
66.00	06600	PHYSICAL THERAPY	0.152316	1,324,284	201,710 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.060818	8,518,812	518,097 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.060288	2,564,408	154,603 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.310485	1,906,988	592,091 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177980	4,916,225	874,990 73.00
74.00	07400	RENAL DIALYSIS	0.062284	2,043,367	127,269 74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0 76.00
76.01	03610	SLEEP LAB	0.571923	0	0 76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.061550	353,305	21,746 76.02
76.03	03950	WOUND CARE	0.584307	633	370 76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.534835	2,223	1,189 90.00
91.00	09100	EMERGENCY	0.029425	10,606,458	312,095 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.177115	1,409,436	249,632 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		71,300,911	5,639,924 200.00
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)		71,300,911	5,639,924 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/28/2020 3:07 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		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		10,849,864		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.105298	0	0	50.00
51.00	05100 RECOVERY ROOM	0.053544	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.306221	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.013087	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.092825	66,539	6,176	54.00
54.01	05401 ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.051305	1,044,891	53,608	60.00
65.00	06500 RESPIRATORY THERAPY	0.067020	16,340	1,095	65.00
66.00	06600 PHYSICAL THERAPY	0.152316	53,881	8,207	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.060818	20,170	1,227	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.060288	44,182	2,664	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.310485	897	279	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.177980	594,005	105,721	73.00
74.00	07400 RENAL DIALYSIS	0.062284	18,499	1,152	74.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.571923	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.061550	213,851	13,163	76.02
76.03	03950 WOUND CARE	0.584307	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.534835	0	0	90.00
91.00	09100 EMERGENCY	0.029425	856,149	25,192	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.177115	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,929,404	218,484	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)		2,929,404		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/28/2020 3:07 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)		6,232,699	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,278,319	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)		36,870	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		42,771	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		281.92	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)		0.00	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)		0.00	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.		0.00	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)		0.00	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)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	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.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	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		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	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)		0.00	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)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		15.01	30.00
31.00	Percentage of Medicaid patient days (see instructions)		43.75	31.00
32.00	Sum of lines 30 and 31		58.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)		37.69	33.00
34.00	Disproportionate share adjustment (see instructions)		801,951	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/28/2020 3:07 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
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,730,578	1,240,127	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,294,377	311,726	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,606,103		
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	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		
47.00	Subtotal (see instructions)	10,998,713		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		10,998,713	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		781,920	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	
53.00	Nursing and Allied Health Managed Care payment		0	
54.00	Special add-on payments for new technologies		0	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	
59.00	Total (sum of amounts on lines 49 through 58)		11,780,633	
60.00	Primary payer payments		2,988	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,777,645	
62.00	Deductibles billed to program beneficiaries		1,066,288	
63.00	Coinurance billed to program beneficiaries		113,553	
64.00	Allowable bad debts (see instructions)		335,983	
65.00	Adjusted reimbursable bad debts (see instructions)		218,389	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		316,815	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,816,193	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		6,428	
70.94	HRR adjustment amount (see instructions)		-74,923	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/28/2020 3:07 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)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,747,698	71.00	
71.01	Sequestration adjustment (see instructions)		214,954	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03	
72.00	Interim payments		10,575,363	72.00	
72.01	Interim payments-PARHM		0	72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-42,619	74.00	
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,294,901	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	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	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	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/28/2020 3:07 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,717	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,830,673	2.00
3.00	OPPS payments		5,189,420	3.00
4.00	Outlier payment (see instructions)		11,382	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)		4,717	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		26,502	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)		26,502	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)		26,502	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		21,785	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)		4,717	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)		5,200,802	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)		931,451	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)		4,274,068	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)		4,274,068	30.00
31.00	Primary payer payments		655	31.00
32.00	Subtotal (line 30 minus line 31)		4,273,413	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)		131,968	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		85,779	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		127,993	36.00
37.00	Subtotal (see instructions)		4,359,192	37.00
38.00	MSP-LCC reconciliation amount from PS&R		78	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)		4,359,114	40.00
40.01	Sequestration adjustment (see instructions)		87,182	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		4,345,808	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-73,876	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/28/2020 3:07 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		300	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		687	2.00
3.00	OPPS payments		1,406	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)		300	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,686	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)		1,686	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)		1,686	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,386	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)		300	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)		1,406	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)		231	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)		1,475	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)		1,475	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,475	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)		1,475	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)		1,475	40.00
40.01	Sequestration adjustment (see instructions)		30	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,482	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-37	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/28/2020 3:07 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		10,575,363		4,345,808	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		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)		10,575,363		4,345,808	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		42,619		73,876	6.02	
7.00	Total Medicare program liability (see instructions)		10,532,744		4,271,932	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: 14-0125 Component CCN: 14-S125		Period: From 01/01/2019 To 12/31/2019		Worksheet E-1 Part I Date/Time Prepared: 8/28/2020 3:07 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		1,494,590		1,482	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		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)		1,494,590		1,482	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		28,671		37	6.02	
7.00	Total Medicare program liability (see instructions)		1,465,919		1,445	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: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/28/2020 3:07 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: 14-0125 Component CCN: 14-S125	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 8/28/2020 3:07 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)			1,689,510 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)			11.309589 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)			1,689,510 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)			1,689,510 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,689,510 18.00
19.00	Deductibles			162,196 19.00
20.00	Subtotal (line 18 minus line 19)			1,527,314 20.00
21.00	Coinsurance			77,407 21.00
22.00	Subtotal (line 20 minus line 21)			1,449,907 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			70,660 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			45,929 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			69,320 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,495,836 26.00
27.00	Direct graduate medical education payments (see instructions)			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)			1,495,836 31.00
31.01	Sequestration adjustment (see instructions)			29,917 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,494,590 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)			-28,671 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

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

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet G

Date/Time Prepared:
8/28/2020 3:07 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	-471,015	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	32,096,263	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,309,962	0	0	0	6.00
7.00	Inventory	2,392,510	0	0	0	7.00
8.00	Prepaid expenses	1,413,745	0	0	0	8.00
9.00	Other current assets	195,547	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)	22,317,088	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,950,173	0	0	0	12.00
13.00	Land improvements	3,266,467	0	0	0	13.00
14.00	Accumulated depreciation	-1,991,490	0	0	0	14.00
15.00	Buildings	21,012,088	0	0	0	15.00
16.00	Accumulated depreciation	-11,168,654	0	0	0	16.00
17.00	Leasehold improvements	34,636,301	0	0	0	17.00
18.00	Accumulated depreciation	-21,718,243	0	0	0	18.00
19.00	Fixed equipment	8,122,632	0	0	0	19.00
20.00	Accumulated depreciation	-5,164,514	0	0	0	20.00
21.00	Automobiles and trucks	47,029	0	0	0	21.00
22.00	Accumulated depreciation	-47,029	0	0	0	22.00
23.00	Major movable equipment	23,250,076	0	0	0	23.00
24.00	Accumulated depreciation	-19,423,026	0	0	0	24.00
25.00	Minor equipment depreciable	6,996,574	0	0	0	25.00
26.00	Accumulated depreciation	-6,202,689	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)	34,565,695	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	3,616,887	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,616,887	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,499,670	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	12,568,983	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,512,800	0	0	0	38.00
39.00	Payroll taxes payable	-200	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	-31,799,978	0	0	0	43.00
44.00	Other current liabilities	1,403,410	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-15,314,985	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,463,764	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,463,764	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-13,851,221	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	74,350,891				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)	74,350,891	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,499,670	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-1

Date/Time Prepared:
8/28/2020 3:07 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		73,155,908		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,194,983				2.00
3.00	Total (sum of line 1 and line 2)		74,350,891		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)		74,350,891		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)		74,350,891		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: 14-0125

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/28/2020 3:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	156,130,292		156,130,292	1.00
2.00	SUBPROVIDER - IPF	23,174,359		23,174,359	2.00
3.00	SUBPROVIDER - IRF	0		0	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	0		0	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)	179,304,651		179,304,651	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,062,894		12,062,894	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)	12,062,894		12,062,894	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	191,367,545		191,367,545	17.00
18.00	Ancillary services	177,733,062	314,997,848	492,730,910	18.00
19.00	Outpatient services	41,262,301	128,950,521	170,212,822	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 & INDUSTRIAL MEDICINE REV	0	8,639,375	8,639,375	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	410,362,908	452,587,744	862,950,652	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		109,104,419		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)		109,104,419		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0125

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-3

Date/Time Prepared:
8/28/2020 3:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	862,950,652	1.00
2.00	Less contractual allowances and discounts on patients' accounts	753,552,461	2.00
3.00	Net patient revenues (line 1 minus line 2)	109,398,191	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	109,104,419	4.00
5.00	Net income from service to patients (line 3 minus line 4)	293,772	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	0	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	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	901,211	24.00
25.00	Total other income (sum of lines 6-24)	901,211	25.00
26.00	Total (line 5 plus line 25)	1,194,983	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)	1,194,983	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0125	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/28/2020 3:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		684,267	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		11,162	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)		73.97	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	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)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		15.01	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		43.75	8.00
9.00	Sum of lines 7 and 8		58.76	9.00
10.00	Allowable disproportionate share percentage (see instructions)		12.64	10.00
11.00	Disproportionate share adjustment (see instructions)		86,491	11.00
12.00	Total prospective capital payments (see instructions)		781,920	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