

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: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/26/2020 4:45 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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.		Date: 8/26/2020 Time: 4:45 pm
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 COMMUNITY FIRST MEDICAL CENTER (14-0251) 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)

 Officer or Administrator of Provider(s)

 CHIEF FINANCIAL OFFICER

 Title

 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	178,604	-131,209	0	0	1.00
2.00	Subprovider - IPF	0	0	0		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	-126		0	7.00
200.00	Total	0	178,604	-131,335	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: 14-0251		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 4:45 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 5645 WEST ADDISON ST.			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60634		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			COMMUNITY FIRST MEDICAL CENTER	140251	16974	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF			CFMC SKILLED NURSING FACILITY	145548	16974		07/01/1985	N P O
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	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N	N	22.03
23.00	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.								
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.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,125	642	0	17	3,598	43
									24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/26/2020 4:45 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.					Y	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.					N		
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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/26/2020 4:45 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00		
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.				N	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)					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	

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 4:45 pm	
			1.00	2.00	3.00
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)				0 76.00
			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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	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.		N	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.		N	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	Y	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	Y	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.		N	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.		N	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	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)				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

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						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
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					115.00
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.	Y					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.	2					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	1,689,163		0		0	118.01
						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

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER			In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0251		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 4:45 pm	
		1.00		2.00			
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)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	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		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						FTE/Campus	
						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		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 4:45 pm
			Beginning 1.00	Ending 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)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0251		Period: From 01/01/2019 To 12/31/2019 Worksheet S-2 Part II Date/Time Prepared: 8/26/2020 4:45 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N	16.00
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)	Y	07/30/2020	Y	07/30/2020
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	18.00
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	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/26/2020 4:45 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 X 107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/26/2020 4:45 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.	MANAGER	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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 4:45 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	193	70,445	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)		193	70,445	0.00	0	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	34.00	20	7,300	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		213	77,745	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	66	24,090		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)		279			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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 4:45 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)	9,379	2,125	23,015			1.00
2.00	HMO and other (see instructions)	5,264	3,598				2.00
3.00	HMO IPF Subprovider	0	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)	9,379	2,125	23,015			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	1,776	702	4,949			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	11,155	2,827	27,964	1.27	727.11	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	8,248	703	12,902	0.00	43.50	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)			60			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)				1.27	770.61	27.00
28.00	Observation Bed Days		226	3,880			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 4:45 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	2,111	478	5,262	1.00
2.00 HMO and other (see instructions)			829	696		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	2,111	478	5,262	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/26/2020 4:45 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	48,709,504	0	48,709,504	1,602,865.00	30.39
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		2,475,036	0	2,475,036	13,868.00	178.47
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	2,608,826	0	2,608,826	90,481.00	28.83
10.00	Excluded area salaries (see instructions)		741,807	0	741,807	16,938.00	43.80
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		232,415	0	232,415	3,998.00	58.13
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		152,495	0	152,495	1,052.00	144.96
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		0	0	0	0.00	0.00
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)		9,872,786	0	9,872,786		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		136,026	0	136,026		
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		28,687	0	28,687		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		358,712	0	358,712		
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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/26/2020 4:45 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	408,005	0	408,005	10,769.00	37.89	26.00
27.00	Administrative & General	5.00	5,085,006	0	5,085,006	195,514.00	26.01	27.00
28.00	Administrative & General under contract (see inst.)		4,400	0	4,400	22.00	200.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,283,595	0	1,283,595	65,466.00	19.61	30.00
31.00	Laundry & Linen Service	8.00	81,766	0	81,766	5,966.00	13.71	31.00
32.00	Housekeeping	9.00	1,070,612	0	1,070,612	76,690.00	13.96	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	914,404	-202,500	711,904	44,899.00	15.86	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	202,500	202,500	12,664.00	15.99	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	932,167	0	932,167	48,431.00	19.25	38.00
39.00	Central Services and Supply	14.00	595,165	0	595,165	30,028.00	19.82	39.00
40.00	Pharmacy	15.00	1,479,318	0	1,479,318	40,114.00	36.88	40.00
41.00	Medical Records & Medical Records Library	16.00	2,414,460	0	2,414,460	68,070.00	35.47	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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/26/2020 4:45 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)	46,238,868	0	46,238,868	1,589,019.00	29.10	1.00
2.00	Excluded area salaries (see instructions)	3,350,633	0	3,350,633	107,419.00	31.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	42,888,235	0	42,888,235	1,481,600.00	28.95	3.00
4.00	Subtotal other wages & related costs (see inst.)	384,910	0	384,910	5,050.00	76.22	4.00
5.00	Subtotal wage-related costs (see inst.)	9,901,473	0	9,901,473	0.00	23.09	5.00
6.00	Total (sum of lines 3 thru 5)	53,174,618	0	53,174,618	1,486,650.00	35.77	6.00
7.00	Total overhead cost (see instructions)	14,268,898	0	14,268,898	598,633.00	23.84	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/26/2020 4:45 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	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)	4,666,533	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	71,576	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	283,521	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,459,164	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	3,739,322	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	176,095	19.00
20.00	State or Federal Unemployment Taxes	0	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)	10,396,211	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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/26/2020 4:45 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	232,415	10,396,211	1.00
2.00	Hospital	232,415	10,396,211	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			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

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/26/2020 4:45 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)			0.166268	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			25,172,870	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?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			143,741,305	6.00
7.00	Medicaid cost (line 1 times line 6)			23,899,579	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			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			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)	35,516,171	473,458	35,989,629	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,905,203	473,458	6,378,661	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)	5,905,203	473,458	6,378,661	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)			14,317,832	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			688,631	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,059,433	27.01
28.00	Non-Medicare bad debt expense (see instructions)			13,258,399	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,575,249	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			8,953,910	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8,953,910	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0251

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

Worksheet A

Date/Time Prepared:
8/26/2020 4:45 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		1,434,821	1,434,821	1,755,708	3,190,529 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	4,361,915	4,361,915 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	408,005	8,177,222	8,585,227	0	8,585,227 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,085,006	26,344,996	31,430,002	-5,863,955	25,566,047 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	1,283,595	3,024,409	4,308,004	0	4,308,004 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,766	606,003	687,769	0	687,769 8.00
9.00	00900	HOUSEKEEPING	1,070,612	434,676	1,505,288	0	1,505,288 9.00
10.00	01000	DIETARY	914,404	883,764	1,798,168	-398,775	1,399,393 10.00
11.00	01100	CAFETERIA	0	0	0	398,215	398,215 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	932,167	127,579	1,059,746	0	1,059,746 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595,165	281,448	876,613	-103,830	772,783 14.00
15.00	01500	PHARMACY	1,479,318	3,721,257	5,200,575	-3,640,028	1,560,547 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,414,460	270,093	2,684,553	0	2,684,553 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	476,309	476,309	0	476,309 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,008,558	1,091,014	10,099,572	-79,940	10,019,632 30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,611,371	246,098	3,857,469	-6,484	3,850,985 34.00
44.00	04400	SKILLED NURSING FACILITY	2,608,826	477,076	3,085,902	-5,538	3,080,364 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,058,947	3,229,443	5,288,390	-2,278,671	3,009,719 50.00
51.00	05100	RECOVERY ROOM	445,839	16,235	462,074	-3,211	458,863 51.00
53.00	05300	ANESTHESIOLOGY	86,959	1,117,881	1,204,840	-30,623	1,174,217 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,361,857	190,416	1,552,273	-25,793	1,526,480 54.00
56.00	05600	RADIOISOTOPE	186,319	237,695	424,014	-29,062	394,952 56.00
57.00	05700	CT SCAN	580,459	116,462	696,921	-43,635	653,286 57.00
58.00	05800	MRI	159,106	67,771	226,877	-5,445	221,432 58.00
59.00	05900	CARDIAC CATHETERIZATION	724,000	762,531	1,486,531	-604,266	882,265 59.00
60.00	06000	LABORATORY	1,784,627	2,741,076	4,525,703	0	4,525,703 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	1,013,676	374,909	1,388,585	-130,330	1,258,255 65.00
66.00	06600	PHYSICAL THERAPY	1,426,239	242,169	1,668,408	-6,008	1,662,400 66.00
67.00	06700	OCCUPATIONAL THERAPY	528,747	10,934	539,681	0	539,681 67.00
68.00	06800	SPEECH PATHOLOGY	159,263	3,238	162,501	0	162,501 68.00
69.00	06900	ELECTROCARDIOLOGY	437,979	35,706	473,685	-6,266	467,419 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,894	851	42,745	0	42,745 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,716,020	1,716,020 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,552,177	1,552,177 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,640,028	3,640,028 73.00
74.00	07400	RENAL DIALYSIS	260,506	15,963	276,469	-8,342	268,127 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	926,864	115,763	1,042,627	-20,918	1,021,709 90.00
91.00	09100	EMERGENCY	6,291,163	3,361,429	9,652,592	-132,943	9,519,649 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,967,697	60,237,237	108,204,934	0	108,204,934 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	173	173	0	173 190.00
194.00	07950	ADDISON CENTRAL PHARMACY	741,807	1,419,812	2,161,619	0	2,161,619 194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0 194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	48,709,504	61,657,222	110,366,726	0	110,366,726 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0251

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

Worksheet A

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	3,190,529	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,361,915	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-120	8,585,107	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,682,977	16,883,070	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-300	4,307,704	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	687,769	8.00
9.00	00900	HOUSEKEEPING	0	1,505,288	9.00
10.00	01000	DIETARY	0	1,399,393	10.00
11.00	01100	CAFETERIA	-209,544	188,671	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,059,746	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	772,783	14.00
15.00	01500	PHARMACY	0	1,560,547	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,911	2,681,642	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	476,309	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,204,588	8,815,044	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-184,576	3,666,409	34.00
44.00	04400	SKILLED NURSING FACILITY	0	3,080,364	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-503,750	2,505,969	50.00
51.00	05100	RECOVERY ROOM	0	458,863	51.00
53.00	05300	ANESTHESIOLOGY	-1,081,325	92,892	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,976	1,521,504	54.00
56.00	05600	RADIOISOTOPE	0	394,952	56.00
57.00	05700	CT SCAN	0	653,286	57.00
58.00	05800	MRI	0	221,432	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	882,265	59.00
60.00	06000	LABORATORY	0	4,525,703	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-6,350	1,251,905	65.00
66.00	06600	PHYSICAL THERAPY	0	1,662,400	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	539,681	67.00
68.00	06800	SPEECH PATHOLOGY	0	162,501	68.00
69.00	06900	ELECTROCARDIOLOGY	0	467,419	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	42,745	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,716,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,552,177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-23,362	3,616,666	73.00
74.00	07400	RENAL DIALYSIS	0	268,127	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,021,709	90.00
91.00	09100	EMERGENCY	-4,471,583	5,048,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,376,362	91,828,572	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	173	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	2,161,619	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,376,362	93,990,364	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA COST				
1.00	CAFETERIA	11.00	202,500	195,715	1.00
	0		202,500	195,715	
	B - RECLASS OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,099,649	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,095,247	2.00
	0		0	6,194,896	
	C - CHARGEABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,716,020	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,552,177	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	3,268,197	
	D - CAPITAL INS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	114,234	1.00
	TOTALS		0	114,234	
	E - CHARGEABLE DRUG COST				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,640,028	1.00
	0		0	3,640,028	
	H - EQUIPMENT RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	266,668	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	266,668	
500.00	Grand Total: Increases		202,500	13,679,738	500.00

RECLASSIFICATIONS

Provider CCN: 14-0251

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

Worksheet A-6

Date/Time Prepared:
8/26/2020 4:45 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
1.00	A - RECLASS CAFETERIA COST						1.00
	DIETARY	10.00	202,500	195,715	0		
	0		202,500	195,715			
1.00	B - RECLASS OTHER CAPITAL COSTS						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	5,736,721	9		
	CAP REL COSTS-BLDG & FIXT	1.00	0	458,175	9		
2.00	0		0	6,194,896		2.00	
1.00	C - CHARGEABLE MEDICAL SUPPLIES						1.00
	ADULTS & PEDIATRICS	30.00	0	59,991	0		
	OPERATING ROOM	50.00	0	2,204,084	0		
2.00	RECOVERY ROOM	51.00	0	3,211	0	2.00	
3.00	ANESTHESIOLOGY	53.00	0	30,623	0	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,793	0	4.00	
5.00	RADIOISOTOPE	56.00	0	1,212	0	5.00	
6.00	CT SCAN	57.00	0	43,635	0	6.00	
7.00	MRI	58.00	0	5,445	0	7.00	
8.00	CARDIAC CATHETERIZATION	59.00	0	604,266	0	8.00	
9.00	RESPIRATORY THERAPY	65.00	0	115,843	0	9.00	
10.00	PHYSICAL THERAPY	66.00	0	6,008	0	10.00	
11.00	ELECTROCARDIOLOGY	69.00	0	6,266	0	11.00	
12.00	RENAL DIALYSIS	74.00	0	8,342	0	12.00	
13.00	CLINIC	90.00	0	20,918	0	13.00	
14.00	EMERGENCY	91.00	0	132,560	0	14.00	
15.00	0		0	3,268,197		15.00	
1.00	D - CAPITAL INS						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	114,234	12		
	TOTALS		0	114,234			
1.00	E - CHARGEABLE DRUG COST						1.00
	PHARMACY	15.00	0	3,640,028	0		
	0		0	3,640,028			
1.00	H - EQUIPMENT RENTAL						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	13,000	10		
	DIETARY	10.00	0	560	0		
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	103,830	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	19,949	0	3.00	
4.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	6,484	0	4.00	
5.00	SKILLED NURSING FACILITY	44.00	0	5,538	0	5.00	
6.00	OPERATING ROOM	50.00	0	74,587	0	6.00	
7.00	RADIOISOTOPE	56.00	0	27,850	0	7.00	
8.00	RESPIRATORY THERAPY	65.00	0	14,487	0	8.00	
9.00	EMERGENCY	91.00	0	383	0	9.00	
10.00	0		0	266,668		10.00	
500.00	Grand Total: Decreases		202,500	13,679,738		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/26/2020 4:45 pm

		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	2,492,380	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	18,612,640	0	0	0	2,318,558	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	8,922,457	15,547,242	0	15,547,242	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	30,027,477	15,547,242	0	15,547,242	2,318,558	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	30,027,477	15,547,242	0	15,547,242	2,318,558	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,492,380	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	16,294,082	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	24,469,699	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	43,256,161	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	43,256,161	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,434,821	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,434,821	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum 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	1,434,821				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,434,821				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/26/2020 4:45 pm

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	16,294,082	0	16,294,082	0.399720	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,469,699	0	24,469,699	0.600280	0	2.00
3.00	Total (sum of lines 1-2)	40,763,781	0	40,763,781	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	3,076,295	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,095,247	266,668	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,171,542	266,668	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	114,234	0	0	3,190,529	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,361,915	2.00
3.00	Total (sum of lines 1-2)	0	114,234	0	0	7,552,444	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0251

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

Worksheet A-8

Date/Time Prepared:
8/26/2020 4:45 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)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-11,996	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,038	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	-7,409,542			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-209,544	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	-23,362	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,911	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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)	B	-44,328	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	MISC INCOME	B	-3,278	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0251

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

Worksheet A-8

Date/Time Prepared:
8/26/2020 4:45 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			
34.00	MISC INCOME	B	-300	OPERATION OF PLANT	7.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	MISC INCOME	B	-2,049,539	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	MEDICAID TAX ASSESSMENTS	A	-6,616,404	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
45.01	MISC INCOME	B	-120	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,376,362				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0251

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

Worksheet A-8-2

Date/Time Prepared:
8/26/2020 4:45 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	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,160,260	1,160,260	0	0	0	1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	198,100	178,100	20,000	211,500	133	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	503,750	503,750	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,081,325	1,081,325	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	1,698	1,698	0	0	0	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	18,450	5,955	12,495	211,500	119	6.00
7.00	91.00	AGGREGATE-EMERGENCY	921,962	801,962	120,000	211,500	800	7.00
8.00	91.00	AGGREGATE-EMERGENCY	3,630,967	3,630,967	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,516,512	7,364,017	152,495		1,052	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	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	13,524	676	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	12,100	605	0	0	0	6.00
7.00	91.00	AGGREGATE-EMERGENCY	81,346	4,067	0	0	0	7.00
8.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			106,970	5,348	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	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,160,260		1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	0	13,524	6,476	184,576		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	503,750		3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,081,325		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	1,698		5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	12,100	395	6,350		6.00
7.00	91.00	AGGREGATE-EMERGENCY	0	81,346	38,654	840,616		7.00
8.00	91.00	AGGREGATE-EMERGENCY	0	0	0	3,630,967		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	106,970	45,525	7,409,542		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,190,529	3,190,529				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,361,915		4,361,915			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,585,107	33,954	46,419	8,665,480		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,883,070	251,894	344,376	912,270	18,391,610	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,307,704	369,469	505,118	230,282	5,412,573	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	687,769	0	0	14,669	702,438	8.00
9.00	00900	HOUSEKEEPING	1,505,288	76,487	104,568	192,072	1,878,415	9.00
10.00	01000	DIETARY	1,399,393	101,685	139,018	127,718	1,767,814	10.00
11.00	01100	CAFETERIA	188,671	99,738	136,356	36,329	461,094	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,059,746	32,132	43,929	167,234	1,303,041	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	772,783	97,351	133,093	106,775	1,110,002	14.00
15.00	01500	PHARMACY	1,560,547	34,155	46,694	265,396	1,906,792	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,681,642	94,475	129,160	433,164	3,338,441	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	476,309	0	0	0	476,309	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,815,044	688,453	941,218	1,616,172	12,060,887	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,666,409	91,925	125,674	647,894	4,531,902	34.00
44.00	04400	SKILLED NURSING FACILITY	3,080,364	250,111	341,938	468,034	4,140,447	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,505,969	263,087	359,678	369,383	3,498,117	50.00
51.00	05100	RECOVERY ROOM	458,863	17,636	24,111	79,985	580,595	51.00
53.00	05300	ANESTHESIOLOGY	92,892	7,725	10,562	15,601	126,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,521,504	126,330	172,712	244,323	2,064,869	54.00
56.00	05600	RADIOISOTOPE	394,952	7,725	10,562	33,426	446,665	56.00
57.00	05700	CT SCAN	653,286	14,044	19,200	104,137	790,667	57.00
58.00	05800	MRI	221,432	3,756	5,135	28,544	258,867	58.00
59.00	05900	CARDIAC CATHETERIZATION	882,265	77,064	105,358	129,888	1,194,575	59.00
60.00	06000	LABORATORY	4,525,703	121,092	165,551	320,169	5,132,515	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,251,905	25,512	34,879	181,858	1,494,154	65.00
66.00	06600	PHYSICAL THERAPY	1,662,400	61,124	83,565	255,873	2,062,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	539,681	15,451	21,123	94,859	671,114	67.00
68.00	06800	SPEECH PATHOLOGY	162,501	10,175	13,910	28,572	215,158	68.00
69.00	06900	ELECTROCARDIOLOGY	467,419	18,516	25,313	78,575	589,823	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	42,745	0	0	7,516	50,261	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,716,020	0	0	0	1,716,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,552,177	0	0	0	1,552,177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,616,666	0	0	0	3,616,666	73.00
74.00	07400	RENAL DIALYSIS	268,127	8,931	12,210	46,736	336,004	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,021,709	40,247	55,023	166,283	1,283,262	90.00
91.00	09100	EMERGENCY	5,048,066	132,259	180,818	1,128,660	6,489,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,828,572	3,172,503	4,337,271	8,532,397	91,652,819	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	173	18,026	24,644	0	42,843	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	2,161,619	0	0	133,083	2,294,702	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,990,364	3,190,529	4,361,915	8,665,480	93,990,364	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
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To 12/31/2019Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	18,391,610					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,316,765	0	6,729,338			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	170,888	0	0	873,326		8.00
9.00	00900	HOUSEKEEPING	456,979	0	203,022	0	2,538,416	9.00
10.00	01000	DIETARY	430,072	0	269,907	0	104,981	10.00
11.00	01100	CAFETERIA	112,174	0	264,739	0	102,970	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	317,003	0	85,290	0	33,174	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	270,040	0	258,404	0	100,506	14.00
15.00	01500	PHARMACY	463,882	0	90,658	0	35,262	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	812,173	0	250,768	0	97,537	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	115,876	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,934,181	0	1,827,401	348,014	710,766	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,102,517	0	244,000	88,668	94,904	34.00
44.00	04400	SKILLED NURSING FACILITY	1,007,284	0	663,881	98,428	258,217	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	851,018	0	698,324	70,154	271,614	50.00
51.00	05100	RECOVERY ROOM	141,247	0	46,813	0	18,208	51.00
53.00	05300	ANESTHESIOLOGY	30,843	0	20,506	0	7,976	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,339	0	335,325	76,241	130,425	54.00
56.00	05600	RADIOISOTOPE	108,664	0	20,506	0	7,976	56.00
57.00	05700	CT SCAN	192,353	0	37,277	0	14,499	57.00
58.00	05800	MRI	62,977	0	9,969	0	3,878	58.00
59.00	05900	CARDIAC CATHETERIZATION	290,615	0	204,556	5,138	79,562	59.00
60.00	06000	LABORATORY	1,248,633	0	321,421	0	125,017	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	363,496	0	67,718	0	26,339	65.00
66.00	06600	PHYSICAL THERAPY	501,875	0	162,244	18,933	63,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,268	0	41,011	0	15,951	67.00
68.00	06800	SPEECH PATHOLOGY	52,343	0	27,007	0	10,505	68.00
69.00	06900	ELECTROCARDIOLOGY	143,492	0	49,147	5,005	19,116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,227	0	0	133	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	417,472	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	377,612	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	879,859	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	81,743	0	23,706	2,090	9,221	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	312,191	0	106,829	4,506	41,551	90.00
91.00	09100	EMERGENCY	1,578,833	0	351,063	152,066	136,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,822,934	0	6,681,492	869,376	2,519,806	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	10,423	0	47,846	3,950	18,610	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	558,253	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	18,391,610	0	6,729,338	873,326	2,538,416	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	2,572,774					10.00
11.00	01100	CAFETERIA	0	940,977				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	36,573	0	1,775,081		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22,685	0	0	1,761,637	14.00
15.00	01500	PHARMACY	0	30,304	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,419	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	41,506	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,450,588	220,867	0	795,173	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	311,114	65,887	0	250,790	0	34.00
44.00	04400	SKILLED NURSING FACILITY	811,072	68,338	0	212,992	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	43,689	0	121,958	0	50.00
51.00	05100	RECOVERY ROOM	0	7,195	0	29,764	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,618	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,169	0	6,596	0	54.00
56.00	05600	RADIOISOTOPE	0	3,173	0	0	0	56.00
57.00	05700	CT SCAN	0	13,636	0	6,537	0	57.00
58.00	05800	MRI	0	2,812	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,002	0	6,759	0	59.00
60.00	06000	LABORATORY	0	54,718	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	27,602	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,305	0	362	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,358	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,095	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,353	0	6,103	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,273	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	924,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	836,661	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,859	0	11,837	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	22,135	0	43,066	0	90.00
91.00	09100	EMERGENCY	0	108,618	0	283,144	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,572,774	928,189	0	1,775,081	1,761,637	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	12,788	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	2,572,774	940,977	0	1,775,081	1,761,637	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
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To 12/31/2019Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,526,898					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,550,338				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,679	710,096	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,269	171,288	0	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	1,085	136,788	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,315	185,910	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,327	33,899	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	86	66,925	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,283	167,575	0	0	0	54.00
56.00	05600	RADIOISOTOPE	67	47,586	0	0	0	56.00
57.00	05700	CT SCAN	208	395,244	0	0	0	57.00
58.00	05800	MRI	0	51,337	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	134,897	0	0	0	59.00
60.00	06000	LABORATORY	0	564,499	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,207	155,349	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	448	81,897	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	37,594	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,232	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	139	159,255	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,183	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	141,001	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,418	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,475,877	536,786	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	452	19,189	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,185	82,811	0	0	0	90.00
91.00	09100	EMERGENCY	8,271	592,579	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,526,898	4,550,338	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	2,526,898	4,550,338	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		633,691				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	21,080,652	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	6,863,339	0	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	7,398,532	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,748,099	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	859,048	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	254,734	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,319,822	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	634,637	0	56.00
57.00	05700	CT SCAN	0	0	0	1,450,421	0	57.00
58.00	05800	MRI	0	0	0	389,840	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,925,104	0	59.00
60.00	06000	LABORATORY	0	0	0	7,446,803	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,137,865	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,925,131	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	940,296	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	317,340	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	982,433	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	66,077	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,199,469	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,832,868	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,509,188	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	487,101	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,897,536	0	90.00
91.00	09100	EMERGENCY	0	633,691	0	10,334,614	-633,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	633,691	0	91,000,949	-633,691	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	123,672	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	2,865,743	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	0	633,691	0	93,990,364	-633,691	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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Cost Center Description		Total	
		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
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	194.00
194.01	07951	PHYSICIAN PRACTICES	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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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	33,954	46,419	80,373	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	251,894	344,376	596,270	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	369,469	505,118	874,587	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	76,487	104,568	181,055	9.00
10.00	01000	DIETARY	0	101,685	139,018	240,703	10.00
11.00	01100	CAFETERIA	0	99,738	136,356	236,094	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	32,132	43,929	76,061	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	97,351	133,093	230,444	14.00
15.00	01500	PHARMACY	0	34,155	46,694	80,849	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	94,475	129,160	223,635	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	688,453	941,218	1,629,671	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	91,925	125,674	217,599	34.00
44.00	04400	SKILLED NURSING FACILITY	0	250,111	341,938	592,049	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	263,087	359,678	622,765	50.00
51.00	05100	RECOVERY ROOM	0	17,636	24,111	41,747	51.00
53.00	05300	ANESTHESIOLOGY	0	7,725	10,562	18,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	126,330	172,712	299,042	54.00
56.00	05600	RADIOISOTOPE	0	7,725	10,562	18,287	56.00
57.00	05700	CT SCAN	0	14,044	19,200	33,244	57.00
58.00	05800	MRI	0	3,756	5,135	8,891	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	77,064	105,358	182,422	59.00
60.00	06000	LABORATORY	0	121,092	165,551	286,643	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	25,512	34,879	60,391	65.00
66.00	06600	PHYSICAL THERAPY	0	61,124	83,565	144,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,451	21,123	36,574	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,175	13,910	24,085	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,516	25,313	43,829	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	8,931	12,210	21,141	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	40,247	55,023	95,270	90.00
91.00	09100	EMERGENCY	0	132,259	180,818	313,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,172,503	4,337,271	7,509,774	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	18,026	24,644	42,670	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	194.01
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	3,190,529	4,361,915	7,552,444	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	604,731					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	43,295	0	920,018			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,619	0	0	5,755		8.00
9.00	00900	HOUSEKEEPING	15,025	0	27,757	0	225,618	9.00
10.00	01000	DIETARY	14,141	0	36,901	0	9,331	10.00
11.00	01100	CAFETERIA	3,688	0	36,194	0	9,152	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	10,423	0	11,661	0	2,949	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,879	0	35,328	0	8,933	14.00
15.00	01500	PHARMACY	15,252	0	12,395	0	3,134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,704	0	34,284	0	8,669	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,810	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	96,492	0	249,841	2,293	63,173	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	36,251	0	33,359	584	8,435	34.00
44.00	04400	SKILLED NURSING FACILITY	33,119	0	90,764	649	22,951	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,981	0	95,473	462	24,141	50.00
51.00	05100	RECOVERY ROOM	4,644	0	6,400	0	1,618	51.00
53.00	05300	ANESTHESIOLOGY	1,014	0	2,803	0	709	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,517	0	45,845	502	11,592	54.00
56.00	05600	RADIOISOTOPE	3,573	0	2,803	0	709	56.00
57.00	05700	CT SCAN	6,325	0	5,096	0	1,289	57.00
58.00	05800	MRI	2,071	0	1,363	0	345	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,555	0	27,966	34	7,072	59.00
60.00	06000	LABORATORY	41,055	0	43,944	0	11,112	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	11,952	0	9,258	0	2,341	65.00
66.00	06600	PHYSICAL THERAPY	16,502	0	22,182	125	5,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,368	0	5,607	0	1,418	67.00
68.00	06800	SPEECH PATHOLOGY	1,721	0	3,692	0	934	68.00
69.00	06900	ELECTROCARDIOLOGY	4,718	0	6,719	33	1,699	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	402	0	0	1	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,726	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,416	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,930	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,688	0	3,241	14	820	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,265	0	14,605	30	3,693	90.00
91.00	09100	EMERGENCY	51,912	0	47,996	1,002	12,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	586,033	0	913,477	5,729	223,964	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	343	0	6,541	26	1,654	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	18,355	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	604,731	0	920,018	5,755	225,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	302,261					10.00
11.00	01100	CAFETERIA	0	285,465				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	11,095	0	113,740		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,882	0	0	291,456	14.00
15.00	01500	PHARMACY	0	9,193	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,599	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	12,592	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	170,422	67,003	0	50,951	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	36,551	19,988	0	16,070	0	34.00
44.00	04400	SKILLED NURSING FACILITY	95,288	20,732	0	13,648	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,254	0	7,815	0	50.00
51.00	05100	RECOVERY ROOM	0	2,183	0	1,907	0	51.00
53.00	05300	ANESTHESIOLOGY	0	491	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,366	0	423	0	54.00
56.00	05600	RADIOISOTOPE	0	963	0	0	0	56.00
57.00	05700	CT SCAN	0	4,137	0	419	0	57.00
58.00	05800	MRI	0	853	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,731	0	433	0	59.00
60.00	06000	LABORATORY	0	16,600	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	8,374	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,104	0	23	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,446	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	939	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,141	0	391	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	386	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	153,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	138,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	867	0	758	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	6,715	0	2,759	0	90.00
91.00	09100	EMERGENCY	0	32,952	0	18,143	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	302,261	281,586	0	113,740	291,456	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	3,879	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	302,261	285,465	0	113,740	291,456	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	123,285					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	312,909				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,106	48,698	0			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	111	11,785	0			34.00
44.00	04400	SKILLED NURSING FACILITY	53	9,411	0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	357	12,791	0			50.00
51.00	05100	RECOVERY ROOM	65	2,332	0			51.00
53.00	05300	ANESTHESIOLOGY	4	4,604	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111	11,529	0			54.00
56.00	05600	RADIOISOTOPE	3	3,274	0			56.00
57.00	05700	CT SCAN	10	27,193	0			57.00
58.00	05800	MRI	0	3,532	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,281	0			59.00
60.00	06000	LABORATORY	0	38,838	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	156	10,688	0			65.00
66.00	06600	PHYSICAL THERAPY	22	5,635	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,587	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	635	0			68.00
69.00	06900	ELECTROCARDIOLOGY	7	10,957	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	150	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,701	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,570	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,796	36,931	0			73.00
74.00	07400	RENAL DIALYSIS	22	1,320	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPS	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	58	5,697	0			90.00
91.00	09100	EMERGENCY	404	40,770	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	123,285	312,909	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0			194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	123,285	312,909	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		16,402				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				2,394,640	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				386,742	0	34.00
44.00	04400	SKILLED NURSING FACILITY				883,005	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				808,465	0	50.00
51.00	05100	RECOVERY ROOM				61,638	0	51.00
53.00	05300	ANESTHESIOLOGY				28,057	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				398,193	0	54.00
56.00	05600	RADIOISOTOPE				29,922	0	56.00
57.00	05700	CT SCAN				78,679	0	57.00
58.00	05800	MRI				17,320	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				240,699	0	59.00
60.00	06000	LABORATORY				441,162	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				104,847	0	65.00
66.00	06600	PHYSICAL THERAPY				207,264	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				55,880	0	67.00
68.00	06800	SPEECH PATHOLOGY				32,271	0	68.00
69.00	06900	ELECTROCARDIOLOGY				72,223	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				1,009	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				176,461	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				155,408	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				186,657	0	73.00
74.00	07400	RENAL DIALYSIS				31,304	0	74.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				140,634	0	90.00
91.00	09100	EMERGENCY				528,860	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	7,461,340	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN				51,234	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY				23,468	0	194.00
194.01	07951	PHYSICIAN PRACTICES				0	0	194.01
200.00		Cross Foot Adjustments	0	16,402	0	16,402	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,402	0	7,552,444	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Total	
		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
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	194.00
194.01	07951	PHYSICIAN PRACTICES	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 4:45 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	253,994					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		253,994				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,703	2,703	48,301,499			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,053	20,053	5,085,006	-18,391,610	75,598,754	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	29,413	29,413	1,283,595	0	5,412,573	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	81,766	0	702,438	8.00
9.00	00900	HOUSEKEEPING	6,089	6,089	1,070,612	0	1,878,415	9.00
10.00	01000	DIETARY	8,095	8,095	711,904	0	1,767,814	10.00
11.00	01100	CAFETERIA	7,940	7,940	202,500	0	461,094	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,558	2,558	932,167	0	1,303,041	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,750	7,750	595,165	0	1,110,002	14.00
15.00	01500	PHARMACY	2,719	2,719	1,479,318	0	1,906,792	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,521	7,521	2,414,460	0	3,338,441	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	476,309	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,807	54,807	9,008,558	0	12,060,887	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,318	7,318	3,611,371	0	4,531,902	34.00
44.00	04400	SKILLED NURSING FACILITY	19,911	19,911	2,608,826	0	4,140,447	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,944	20,944	2,058,947	0	3,498,117	50.00
51.00	05100	RECOVERY ROOM	1,404	1,404	445,839	0	580,595	51.00
53.00	05300	ANESTHESIOLOGY	615	615	86,959	0	126,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,057	10,057	1,361,857	0	2,064,869	54.00
56.00	05600	RADIOISOTOPE	615	615	186,319	0	446,665	56.00
57.00	05700	CT SCAN	1,118	1,118	580,459	0	790,667	57.00
58.00	05800	MRI	299	299	159,106	0	258,867	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,135	6,135	724,000	0	1,194,575	59.00
60.00	06000	LABORATORY	9,640	9,640	1,784,627	0	5,132,515	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,031	2,031	1,013,676	0	1,494,154	65.00
66.00	06600	PHYSICAL THERAPY	4,866	4,866	1,426,239	0	2,062,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,230	1,230	528,747	0	671,114	67.00
68.00	06800	SPEECH PATHOLOGY	810	810	159,263	0	215,158	68.00
69.00	06900	ELECTROCARDIOLOGY	1,474	1,474	437,979	0	589,823	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	41,894	0	50,261	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,716,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,552,177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,616,666	73.00
74.00	07400	RENAL DIALYSIS	711	711	260,506	0	336,004	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,204	3,204	926,864	0	1,283,262	90.00
91.00	09100	EMERGENCY	10,529	10,529	6,291,163	0	6,489,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	252,559	252,559	47,559,692	-18,391,610	73,261,209	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,435	1,435	0	0	42,843	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	741,807	0	2,294,702	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	3,190,529	4,361,915	8,665,480		18,391,610	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.561435	17.173299	0.179404		0.243279	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			80,373		604,731	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 4:45 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	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001664		0.007999	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: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	201,825				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,153,033			8.00
9.00	00900	HOUSEKEEPING	0	6,089	0	195,736		9.00
10.00	01000	DIETARY	0	8,095	0	8,095	122,778	10.00
11.00	01100	CAFETERIA	0	7,940	0	7,940	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	2,558	0	2,558	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,750	0	7,750	0	14.00
15.00	01500	PHARMACY	0	2,719	0	2,719	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,521	0	7,521	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	54,807	459,474	54,807	69,225	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	7,318	117,067	7,318	14,847	34.00
44.00	04400	SKILLED NURSING FACILITY	0	19,911	129,952	19,911	38,706	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,944	92,623	20,944	0	50.00
51.00	05100	RECOVERY ROOM	0	1,404	0	1,404	0	51.00
53.00	05300	ANESTHESIOLOGY	0	615	0	615	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,057	100,659	10,057	0	54.00
56.00	05600	RADIOISOTOPE	0	615	0	615	0	56.00
57.00	05700	CT SCAN	0	1,118	0	1,118	0	57.00
58.00	05800	MRI	0	299	0	299	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,135	6,783	6,135	0	59.00
60.00	06000	LABORATORY	0	9,640	0	9,640	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,031	0	2,031	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,866	24,997	4,866	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,230	0	1,230	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	810	0	810	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,474	6,608	1,474	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	176	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	711	2,760	711	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,204	5,949	3,204	0	90.00
91.00	09100	EMERGENCY	0	10,529	200,770	10,529	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	200,390	1,147,818	194,301	122,778	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,435	5,215	1,435	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	0	6,729,338	873,326	2,538,416	2,572,774	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	33.342440	0.757416	12.968570	20.954682	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	920,018	5,755	225,618	302,261	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.558494	0.004991	1.152665	2.461850	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	6.00	7.00	8.00	9.00	10.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	59,897					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	2,328	0	568,063			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,444	0	0	3,268,197		14.00
15.00	01500	PHARMACY	1,929	0	0	0	3,715,037	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,273	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,642	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,059	0	254,472	0	33,342	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,194	0	80,258	0	3,336	34.00
44.00	04400	SKILLED NURSING FACILITY	4,350	0	68,162	0	1,595	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,781	0	39,029	0	10,754	50.00
51.00	05100	RECOVERY ROOM	458	0	9,525	0	1,951	51.00
53.00	05300	ANESTHESIOLOGY	103	0	0	0	127	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,175	0	2,111	0	3,356	54.00
56.00	05600	RADIOISOTOPE	202	0	0	0	99	56.00
57.00	05700	CT SCAN	868	0	2,092	0	306	57.00
58.00	05800	MRI	179	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	573	0	2,163	0	0	59.00
60.00	06000	LABORATORY	3,483	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,757	0	0	0	4,715	65.00
66.00	06600	PHYSICAL THERAPY	2,120	0	116	0	658	66.00
67.00	06700	OCCUPATIONAL THERAPY	723	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	197	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	659	0	1,953	0	204	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	81	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,716,020	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,552,177	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,640,028	73.00
74.00	07400	RENAL DIALYSIS	182	0	3,788	0	664	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,409	0	13,782	0	1,742	90.00
91.00	09100	EMERGENCY	6,914	0	90,612	0	12,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		59,083	0	568,063	3,268,197	3,715,037	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	814	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)		940,977	0	1,775,081	1,761,637	2,526,898	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		15.709919	0.000000	3.124796	0.539024	0.680181	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		285,465	0	113,740	291,456	123,285	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		4.765932	0.000000	0.200224	0.089179	0.033185	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
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: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	543,503,282					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	84,802,898	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	20,459,643	0	0	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	16,338,753	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,206,190	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	4,049,085	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	7,993,859	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,016,076	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	5,683,915	0	0	0	0	56.00
57.00	05700	CT SCAN	47,210,210	0	0	0	0	57.00
58.00	05800	MRI	6,131,931	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,112,890	0	0	0	0	59.00
60.00	06000	LABORATORY	67,426,969	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	18,555,753	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,782,288	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,490,455	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,102,744	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,022,308	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	260,728	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,841,998	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,933,305	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,116,817	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,292,016	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,891,391	0	0	0	0	90.00
91.00	09100	EMERGENCY	70,781,060	0	0	0	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	543,503,282	0	0	0	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	4,550,338	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008372	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	312,909	0	0	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS	SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000576	0.000000	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000			207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet B-1
Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	100		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	194.01
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)	633,691	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6,336.910000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,402	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet B-1
Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		22.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	164.020000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 4:45 pm

			Title XVIII	Hospital	PPS			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,080,652		21,080,652	0	21,080,652	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,863,339		6,863,339	6,476	6,869,815	34.00
44.00	04400	SKILLED NURSING FACILITY	7,398,532		7,398,532	0	7,398,532	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,748,099		5,748,099	0	5,748,099	50.00
51.00	05100	RECOVERY ROOM	859,048		859,048	0	859,048	51.00
53.00	05300	ANESTHESIOLOGY	254,734		254,734	0	254,734	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,319,822		3,319,822	0	3,319,822	54.00
56.00	05600	RADIOISOTOPE	634,637		634,637	0	634,637	56.00
57.00	05700	CT SCAN	1,450,421		1,450,421	0	1,450,421	57.00
58.00	05800	MRI	389,840		389,840	0	389,840	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,925,104		1,925,104	0	1,925,104	59.00
60.00	06000	LABORATORY	7,446,803		7,446,803	0	7,446,803	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,137,865	0	2,137,865	395	2,138,260	65.00
66.00	06600	PHYSICAL THERAPY	2,925,131	0	2,925,131	0	2,925,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	940,296	0	940,296	0	940,296	67.00
68.00	06800	SPEECH PATHOLOGY	317,340	0	317,340	0	317,340	68.00
69.00	06900	ELECTROCARDIOLOGY	982,433		982,433	0	982,433	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,077		66,077	0	66,077	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,199,469		3,199,469	0	3,199,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,832,868		2,832,868	0	2,832,868	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,509,188		7,509,188	0	7,509,188	73.00
74.00	07400	RENAL DIALYSIS	487,101		487,101	0	487,101	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,897,536		1,897,536	0	1,897,536	90.00
91.00	09100	EMERGENCY	9,700,923		9,700,923	38,654	9,739,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,041,183		3,041,183		3,041,183	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
200.00		Subtotal (see instructions)	93,408,441	0	93,408,441	45,525	93,453,966	200.00
201.00		Less Observation Beds	3,041,183		3,041,183		3,041,183	201.00
202.00		Total (see instructions)	90,367,258	0	90,367,258	45,525	90,412,783	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0251		Period: From 01/01/2019 To 12/31/2019		Worksheet C Part I Date/Time Prepared: 8/26/2020 4:45 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	71,829,109		71,829,109				30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	20,459,643		20,459,643				34.00	
44.00	04400	SKILLED NURSING FACILITY	16,338,753		16,338,753				44.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	11,792,054	10,414,136	22,206,190	0.258851	0.000000		50.00	
51.00	05100	RECOVERY ROOM	2,167,263	1,881,822	4,049,085	0.212159	0.000000		51.00	
53.00	05300	ANESTHESIOLOGY	3,515,466	4,478,393	7,993,859	0.031866	0.000000		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,110,953	12,905,123	20,016,076	0.165858	0.000000		54.00	
56.00	05600	RADIOISOTOPE	1,842,685	3,841,230	5,683,915	0.111655	0.000000		56.00	
57.00	05700	CT SCAN	16,183,101	31,027,109	47,210,210	0.030723	0.000000		57.00	
58.00	05800	MRI	2,497,727	3,634,204	6,131,931	0.063575	0.000000		58.00	
59.00	05900	CARDIAC CATHETERIZATION	11,229,753	4,883,137	16,112,890	0.119476	0.000000		59.00	
60.00	06000	LABORATORY	42,281,680	25,145,289	67,426,969	0.110442	0.000000		60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30	
65.00	06500	RESPIRATORY THERAPY	17,550,998	1,004,755	18,555,753	0.115213	0.000000		65.00	
66.00	06600	PHYSICAL THERAPY	7,559,557	2,222,731	9,782,288	0.299023	0.000000		66.00	
67.00	06700	OCCUPATIONAL THERAPY	4,111,755	378,700	4,490,455	0.209399	0.000000		67.00	
68.00	06800	SPEECH PATHOLOGY	1,033,192	69,552	1,102,744	0.287773	0.000000		68.00	
69.00	06900	ELECTROCARDIOLOGY	9,902,974	9,119,334	19,022,308	0.051646	0.000000		69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	185,246	75,482	260,728	0.253433	0.000000		70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,136,511	3,705,487	16,841,998	0.189970	0.000000		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,647,782	2,285,523	7,933,305	0.357085	0.000000		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	52,788,064	11,328,753	64,116,817	0.117117	0.000000		73.00	
74.00	07400	RENAL DIALYSIS	2,143,686	148,330	2,292,016	0.212521	0.000000		74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99	
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	2,031,472	7,859,919	9,891,391	0.191837	0.000000		90.00	
91.00	09100	EMERGENCY	18,398,279	52,382,781	70,781,060	0.137055	0.000000		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,134,562	10,839,227	12,973,789	0.234410	0.000000		92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000		93.99	
200.00		Subtotal (see instructions)	343,872,265	199,631,017	543,503,282				200.00	
201.00		Less Observation Beds							201.00	
202.00		Total (see instructions)	343,872,265	199,631,017	543,503,282				202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 4:45 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
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.258851			50.00
51.00	05100	RECOVERY ROOM	0.212159			51.00
53.00	05300	ANESTHESIOLOGY	0.031866			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165858			54.00
56.00	05600	RADIOISOTOPE	0.111655			56.00
57.00	05700	CT SCAN	0.030723			57.00
58.00	05800	MRI	0.063575			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.119476			59.00
60.00	06000	LABORATORY	0.110442			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.115234			65.00
66.00	06600	PHYSICAL THERAPY	0.299023			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209399			67.00
68.00	06800	SPEECH PATHOLOGY	0.287773			68.00
69.00	06900	ELECTROCARDIOLOGY	0.051646			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.253433			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.189970			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.357085			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117117			73.00
74.00	07400	RENAL DIALYSIS	0.212521			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.191837			90.00
91.00	09100	EMERGENCY	0.137601			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.234410			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 4:45 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,080,652		21,080,652	0	21,080,652	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,863,339		6,863,339	6,476	6,869,815	34.00
44.00	04400	SKILLED NURSING FACILITY	7,398,532		7,398,532	0	7,398,532	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,748,099		5,748,099	0	5,748,099	50.00
51.00	05100	RECOVERY ROOM	859,048		859,048	0	859,048	51.00
53.00	05300	ANESTHESIOLOGY	254,734		254,734	0	254,734	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,319,822		3,319,822	0	3,319,822	54.00
56.00	05600	RADIOISOTOPE	634,637		634,637	0	634,637	56.00
57.00	05700	CT SCAN	1,450,421		1,450,421	0	1,450,421	57.00
58.00	05800	MRI	389,840		389,840	0	389,840	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,925,104		1,925,104	0	1,925,104	59.00
60.00	06000	LABORATORY	7,446,803		7,446,803	0	7,446,803	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,137,865	0	2,137,865	395	2,138,260	65.00
66.00	06600	PHYSICAL THERAPY	2,925,131	0	2,925,131	0	2,925,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	940,296	0	940,296	0	940,296	67.00
68.00	06800	SPEECH PATHOLOGY	317,340	0	317,340	0	317,340	68.00
69.00	06900	ELECTROCARDIOLOGY	982,433		982,433	0	982,433	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,077		66,077	0	66,077	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,199,469		3,199,469	0	3,199,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,832,868		2,832,868	0	2,832,868	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,509,188		7,509,188	0	7,509,188	73.00
74.00	07400	RENAL DIALYSIS	487,101		487,101	0	487,101	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,897,536		1,897,536	0	1,897,536	90.00
91.00	09100	EMERGENCY	9,700,923		9,700,923	38,654	9,739,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,041,183		3,041,183		3,041,183	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
200.00		Subtotal (see instructions)	93,408,441	0	93,408,441	45,525	93,453,966	200.00
201.00		Less Observation Beds	3,041,183		3,041,183		3,041,183	201.00
202.00		Total (see instructions)	90,367,258	0	90,367,258	45,525	90,412,783	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0251		Period: From 01/01/2019 To 12/31/2019		Worksheet C Part I Date/Time Prepared: 8/26/2020 4:45 pm		
			Title XIX			Hospital		Cost	
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	71,829,109		71,829,109			30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	20,459,643		20,459,643			34.00	
44.00	04400	SKILLED NURSING FACILITY	16,338,753		16,338,753			44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,792,054	10,414,136	22,206,190	0.258851	0.000000	50.00	
51.00	05100	RECOVERY ROOM	2,167,263	1,881,822	4,049,085	0.212159	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	3,515,466	4,478,393	7,993,859	0.031866	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,110,953	12,905,123	20,016,076	0.165858	0.000000	54.00	
56.00	05600	RADIOISOTOPE	1,842,685	3,841,230	5,683,915	0.111655	0.000000	56.00	
57.00	05700	CT SCAN	16,183,101	31,027,109	47,210,210	0.030723	0.000000	57.00	
58.00	05800	MRI	2,497,727	3,634,204	6,131,931	0.063575	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	11,229,753	4,883,137	16,112,890	0.119476	0.000000	59.00	
60.00	06000	LABORATORY	42,281,680	25,145,289	67,426,969	0.110442	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	17,550,998	1,004,755	18,555,753	0.115213	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	7,559,557	2,222,731	9,782,288	0.299023	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	4,111,755	378,700	4,490,455	0.209399	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	1,033,192	69,552	1,102,744	0.287773	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	9,902,974	9,119,334	19,022,308	0.051646	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	185,246	75,482	260,728	0.253433	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,136,511	3,705,487	16,841,998	0.189970	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,647,782	2,285,523	7,933,305	0.357085	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	52,788,064	11,328,753	64,116,817	0.117117	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	2,143,686	148,330	2,292,016	0.212521	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,031,472	7,859,919	9,891,391	0.191837	0.000000	90.00	
91.00	09100	EMERGENCY	18,398,279	52,382,781	70,781,060	0.137055	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,134,562	10,839,227	12,973,789	0.234410	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
200.00		Subtotal (see instructions)	343,872,265	199,631,017	543,503,282			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	343,872,265	199,631,017	543,503,282			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/26/2020 4:45 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	2,394,640	0	2,394,640	26,895	89.04	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	386,742		386,742	4,949	78.15	34.00
44.00	SKILLED NURSING FACILITY	883,005		883,005	12,902	68.44	44.00
200.00	Total (lines 30 through 199)	3,664,387		3,664,387	44,746		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	9,379	835,106				30.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,776	138,794				34.00
44.00	SKILLED NURSING FACILITY	8,248	564,493				44.00
200.00	Total (lines 30 through 199)	19,403	1,538,393				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/26/2020 4:45 pm

				Title XVIII		Hospital	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	808,465	22,206,190	0.036407	4,244,984	154,547	50.00
51.00	05100	RECOVERY ROOM	61,638	4,049,085	0.015223	745,507	11,349	51.00
53.00	05300	ANESTHESIOLOGY	28,057	7,993,859	0.003510	1,318,879	4,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	398,193	20,016,076	0.019894	2,806,842	55,839	54.00
56.00	05600	RADIOISOTOPE	29,922	5,683,915	0.005264	785,253	4,134	56.00
57.00	05700	CT SCAN	78,679	47,210,210	0.001667	6,211,836	10,355	57.00
58.00	05800	MRI	17,320	6,131,931	0.002825	921,646	2,604	58.00
59.00	05900	CARDIAC CATHETERIZATION	240,699	16,112,890	0.014938	3,478,705	51,965	59.00
60.00	06000	LABORATORY	441,162	67,426,969	0.006543	15,315,126	100,207	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	104,847	18,555,753	0.005650	6,072,405	34,309	65.00
66.00	06600	PHYSICAL THERAPY	207,264	9,782,288	0.021188	778,998	16,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	55,880	4,490,455	0.012444	304,349	3,787	67.00
68.00	06800	SPEECH PATHOLOGY	32,271	1,102,744	0.029264	316,017	9,248	68.00
69.00	06900	ELECTROCARDIOLOGY	72,223	19,022,308	0.003797	4,288,817	16,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,009	260,728	0.003870	81,192	314	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	176,461	16,841,998	0.010477	4,351,500	45,591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,408	7,933,305	0.019589	1,772,905	34,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	186,657	64,116,817	0.002911	17,782,749	51,766	73.00
74.00	07400	RENAL DIALYSIS	31,304	2,292,016	0.013658	1,020,574	13,939	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	140,634	9,891,391	0.014218	818,382	11,636	90.00
91.00	09100	EMERGENCY	528,860	70,781,060	0.007472	6,998,857	52,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	345,460	12,973,789	0.026628	826,214	22,000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	4,142,413	434,875,777		81,241,737	708,033	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0251		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/26/2020 4:45 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	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0	0	0	0	34.00	
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	26,895	0.00	9,379		30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT			0	4,949	0.00	1,776		34.00	
44.00	04400	SKILLED NURSING FACILITY			0	12,902	0.00	8,248		44.00	
200.00		Total (lines 30 through 199)			0	44,746		19,403		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	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0						34.00	
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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			Title XVIII		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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
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: 14-0251		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 4:45 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	22,206,190	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,049,085	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,993,859	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,016,076	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,683,915	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	47,210,210	0.000000	57.00
58.00	05800	MRI	0	0	0	6,131,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	16,112,890	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	67,426,969	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,555,753	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,782,288	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,490,455	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,102,744	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,022,308	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	260,728	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,841,998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,933,305	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	64,116,817	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,292,016	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	9,891,391	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	70,781,060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,973,789	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	434,875,777		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 4:45 pm

				Title XVIII		Hospital		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	4,244,984	0	2,864,988	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	745,507	0	495,550	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.000000	1,318,879	0	1,167,312	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,806,842	0	2,296,846	0	54.00	
56.00	05600	RADIOISOTOPE	0.000000	785,253	0	1,269,671	0	56.00	
57.00	05700	CT SCAN	0.000000	6,211,836	0	6,309,135	0	57.00	
58.00	05800	MRI	0.000000	921,646	0	1,135,912	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	3,478,705	0	1,790,301	0	59.00	
60.00	06000	LABORATORY	0.000000	15,315,126	0	3,689,002	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.000000	6,072,405	0	205,814	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	778,998	0	25,749	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	304,349	0	8,325	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	316,017	0	8,718	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,288,817	0	2,320,525	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	81,192	0	23,438	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,351,500	0	935,776	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,772,905	0	734,754	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	17,782,749	0	2,246,944	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	1,020,574	0	44,666	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	818,382	0	2,110,622	0	90.00	
91.00	09100	EMERGENCY	0.000000	6,998,857	0	7,093,437	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	826,214	0	2,424,238	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00		Total (lines 50 through 199)		81,241,737	0	39,201,723	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/26/2020 4:45 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	0.258851	2,864,988	0	0	741,605	50.00
51.00	05100	RECOVERY ROOM	0.212159	495,550	0	0	105,135	51.00
53.00	05300	ANESTHESIOLOGY	0.031866	1,167,312	0	0	37,198	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165858	2,296,846	0	0	380,950	54.00
56.00	05600	RADIOISOTOPE	0.111655	1,269,671	0	0	141,765	56.00
57.00	05700	CT SCAN	0.030723	6,309,135	0	0	193,836	57.00
58.00	05800	MRI	0.063575	1,135,912	0	0	72,216	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.119476	1,790,301	0	0	213,898	59.00
60.00	06000	LABORATORY	0.110442	3,689,002	0	0	407,421	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.115213	205,814	0	0	23,712	65.00
66.00	06600	PHYSICAL THERAPY	0.299023	25,749	0	0	7,700	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209399	8,325	0	0	1,743	67.00
68.00	06800	SPEECH PATHOLOGY	0.287773	8,718	0	0	2,509	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051646	2,320,525	0	0	119,846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.253433	23,438	0	0	5,940	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.189970	935,776	0	0	177,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.357085	734,754	0	0	262,370	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117117	2,246,944	0	29,930	263,155	73.00
74.00	07400	RENAL DIALYSIS	0.212521	44,666	0	0	9,492	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.191837	2,110,622	0	54	404,895	90.00
91.00	09100	EMERGENCY	0.137055	7,093,437	0	0	972,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.234410	2,424,238	0	0	568,266	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		39,201,723	0	29,984	5,113,612	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		39,201,723	0	29,984	5,113,612	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/26/2020 4:45 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,505		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	10		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	3,515		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,515		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:

Worksheet D

Component CCN: 14-5548

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/26/2020 4:45 pm

Title XVIII

Skilled Nursing
Facility

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	0.258851	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.212159	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.031866	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.165858	0	0	0	0 54.00
56.00	05600 RADIOISOTOPE	0.111655	0	0	0	0 56.00
57.00	05700 CT SCAN	0.030723	0	0	0	0 57.00
58.00	05800 MRI	0.063575	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.119476	0	0	0	0 59.00
60.00	06000 LABORATORY	0.110442	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.115213	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.299023	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.209399	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.287773	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.051646	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.253433	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.189970	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.357085	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117117	0	0	9,968	0 73.00
74.00	07400 RENAL DIALYSIS	0.212521	0	0	0	0 74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.191837	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.137055	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.234410	0	0	0	0 92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
200.00	Subtotal (see instructions)		0	0	9,968	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	9,968	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0251

Period:

Worksheet D

Component CCN:14-5548

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/26/2020 4:45 pm

Title XVIII

Skilled Nursing
Facility

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
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,167	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
	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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	1,167	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,167	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0251		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/26/2020 4:45 pm		
					Title XIX		Hospital		Cost		
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	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0	0	0	0	34.00	
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	26,895	0.00	2,125		30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT			0	4,949	0.00	702		34.00	
44.00	04400	SKILLED NURSING FACILITY			0	12,902	0.00	703		44.00	
200.00		Total (lines 30 through 199)			0	44,746		3,530		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	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0						34.00	
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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description			Title XIX		Hospital		Cost	
			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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
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: 14-0251		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 4:45 pm	
				Title XIX		Hospital		Cost	
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	22,206,190	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	4,049,085	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	7,993,859	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	20,016,076	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	5,683,915	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	47,210,210	0.000000	57.00
58.00	05800	MRI		0	0	0	6,131,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	16,112,890	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	67,426,969	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	18,555,753	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	9,782,288	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	4,490,455	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,102,744	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	19,022,308	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	260,728	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	16,841,998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	7,933,305	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	64,116,817	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	2,292,016	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	9,891,391	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	70,781,060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	12,973,789	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)		0	0	0	434,875,777		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description		Title XIX			Hospital		Cost	
		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	969,270	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	196,513	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	287,893	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	634,942	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	110,304	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	1,581,624	0	0	0	57.00
58.00	05800	MRI	0.000000	197,461	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,013,877	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,418,446	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	1,823,422	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	201,079	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	42,304	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	44,254	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	688,102	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	11,666	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,060,832	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	349,639	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,479,013	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	205,320	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	148,515	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,939,155	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	140,437	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		21,544,068	0	0	0	200.00

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 4:45 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)		26,895	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26,895	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)		23,015	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)		9,379	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)		21,080,652	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)		21,080,652	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)		21,080,652	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)		783.81	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,351,354	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)		7,351,354	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	6,869,815	4,949	1,388.12	1,776	2,465,301	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)					10,611,160	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					20,427,815	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)					973,900	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					708,033	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,681,933	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					18,745,882	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)					3,880	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					783.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,041,183	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
8/26/2020 4:45 pm

		Title XVIII		Hospital	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	2,394,640	21,080,652	0.113594	3,041,183	345,460	90.00
91.00 Nursing School cost	0	21,080,652	0.000000	3,041,183	0	91.00
92.00 Allied health cost	0	21,080,652	0.000000	3,041,183	0	92.00
93.00 All other Medical Education	0	21,080,652	0.000000	3,041,183	0	93.00

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0251	Period: From 01/01/2019	Worksheet D-1	
		Component CCN: 14-5548	To 12/31/2019	Date/Time Prepared: 8/26/2020 4:45 pm	
		Title XVIII	Skilled Nursing Facility	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)		12,902	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,902	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)		12,902	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)		8,248	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)		7,398,532	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)		7,398,532	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)		7,398,532	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)			38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00	

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER			In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0251 Component CCN: 14-5548		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/26/2020 4:45 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)			
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)					
		1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)							42.00	
Intensive Care Type Inpatient Hospital Units									
43.00	INTENSIVE CARE UNIT							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)							48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							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)							50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)							52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							53.00	
TARGET AMOUNT AND LIMIT COMPUTATION									
54.00	Program discharges							54.00	
55.00	Target amount per discharge							55.00	
56.00	Target amount (line 54 x line 55)							56.00	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.00	
58.00	Bonus payment (see instructions)							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							59.00	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							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)							61.00	
62.00	Relief payment (see instructions)							62.00	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							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)							64.00	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							65.00	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							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)							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)							68.00	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							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)						7,398,532	70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						573.44	71.00	
72.00	Program routine service cost (line 9 x line 71)						4,729,733	72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0	73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						4,729,733	74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0	75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00	76.00	
77.00	Program capital-related costs (line 9 x line 76)						0	77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)						0	78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0	79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0	80.00	
81.00	Inpatient routine service cost per diem limitation						0.00	81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0	82.00	
83.00	Reasonable inpatient routine service costs (see instructions)						4,729,733	83.00	
84.00	Program inpatient ancillary services (see instructions)						2,963,776	84.00	
85.00	Utilization review - physician compensation (see instructions)						0	85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						7,693,509	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: 14-0251

Period:

Worksheet D-1

Component CCN: 14-5548

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 4:45 pm

Title XVIII

Skilled Nursing
Facility

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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 4:45 pm	
		Title XIX	Hospital	Cost	
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)			26,895	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			26,895	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)			23,015	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)			2,125	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)			21,080,652	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)			21,080,652	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)			21,080,652	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)			783.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,665,596	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)			1,665,596	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	6,863,339	4,949	1,386.81	702	973,541	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)					2,758,828	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,397,965	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)					0	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)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	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)					3,880	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					783.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,041,183	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
8/26/2020 4:45 pm

		Title XIX		Hospital	Cost	
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	2,394,640	21,080,652	0.113594	3,041,183	345,460
91.00	Nursing School cost	0	21,080,652	0.000000	3,041,183	0
92.00	Allied health cost	0	21,080,652	0.000000	3,041,183	0
93.00	All other Medical Education	0	21,080,652	0.000000	3,041,183	0

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/26/2020 4:45 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		27,098,846	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		7,230,347	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.258851	4,244,984	50.00
51.00	05100	RECOVERY ROOM	0.212159	745,507	51.00
53.00	05300	ANESTHESIOLOGY	0.031866	1,318,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165858	2,806,842	54.00
56.00	05600	RADIOISOTOPE	0.111655	785,253	56.00
57.00	05700	CT SCAN	0.030723	6,211,836	57.00
58.00	05800	MRI	0.063575	921,646	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.119476	3,478,705	59.00
60.00	06000	LABORATORY	0.110442	15,315,126	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.115234	6,072,405	65.00
66.00	06600	PHYSICAL THERAPY	0.299023	778,998	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209399	304,349	67.00
68.00	06800	SPEECH PATHOLOGY	0.287773	316,017	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051646	4,288,817	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.253433	81,192	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.189970	4,351,500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.357085	1,772,905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117117	17,782,749	73.00
74.00	07400	RENAL DIALYSIS	0.212521	1,020,574	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.191837	818,382	90.00
91.00	09100	EMERGENCY	0.137601	6,998,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.234410	826,214	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		81,241,737	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		81,241,737	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/26/2020 4:45 pm	
		Title XVIII	Skilled Nursing Facility	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
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.258851	856	222	50.00
51.00	05100 RECOVERY ROOM	0.212159	2,522	535	51.00
53.00	05300 ANESTHESIOLOGY	0.031866	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.165858	205,127	34,022	54.00
56.00	05600 RADIOISOTOPE	0.111655	5,691	635	56.00
57.00	05700 CT SCAN	0.030723	456	14	57.00
58.00	05800 MRI	0.063575	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.119476	24,842	2,968	59.00
60.00	06000 LABORATORY	0.110442	2,411,724	266,356	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.115234	1,232,959	142,079	65.00
66.00	06600 PHYSICAL THERAPY	0.299023	4,095,049	1,224,514	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.209399	2,383,490	499,100	67.00
68.00	06800 SPEECH PATHOLOGY	0.287773	224,034	64,471	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051646	41,625	2,150	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.253433	614	156	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.189970	873,498	165,938	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.357085	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117117	4,781,563	560,002	73.00
74.00	07400 RENAL DIALYSIS	0.212521	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.191837	0	0	90.00
91.00	09100 EMERGENCY	0.137601	4,463	614	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.234410	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		16,288,513	2,963,776	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		16,288,513		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/26/2020 4:45 pm	
		Title XIX	Hospital	Cost	
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		5,899,836		30.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		2,891,829		34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.258851	969,270	250,897	50.00
51.00	05100 RECOVERY ROOM	0.212159	196,513	41,692	51.00
53.00	05300 ANESTHESIOLOGY	0.031866	287,893	9,174	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.165858	634,942	105,310	54.00
56.00	05600 RADIOISOTOPE	0.111655	110,304	12,316	56.00
57.00	05700 CT SCAN	0.030723	1,581,624	48,592	57.00
58.00	05800 MRI	0.063575	197,461	12,554	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.119476	1,013,877	121,134	59.00
60.00	06000 LABORATORY	0.110442	4,418,446	487,982	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.115213	1,823,422	210,082	65.00
66.00	06600 PHYSICAL THERAPY	0.299023	201,079	60,127	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.209399	42,304	8,858	67.00
68.00	06800 SPEECH PATHOLOGY	0.287773	44,254	12,735	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051646	688,102	35,538	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.253433	11,666	2,957	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.189970	1,060,832	201,526	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.357085	349,639	124,851	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117117	5,479,013	641,686	73.00
74.00	07400 RENAL DIALYSIS	0.212521	205,320	43,635	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.191837	148,515	28,491	90.00
91.00	09100 EMERGENCY	0.137055	1,939,155	265,771	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.234410	140,437	32,920	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		21,544,068	2,758,828	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)		21,544,068		202.00

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/26/2020 4:45 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)			13,888,587	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			4,488,947	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)			121,874	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			23,852	2.04
3.00	Managed Care Simulated Payments			7,749,540	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			202.21	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)			1.56	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.			0.11	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).			1.50	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)			2.95	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			1.27	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)			1.27	12.00
13.00	Total allowable FTE count for the prior year.			2.95	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.			1.96	14.00
15.00	Sum of lines 12 through 14 divided by 3.			2.06	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			2.06	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.010187	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.014766	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.010187	21.00
22.00	IME payment adjustment (see instructions)			102,050	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			43,033	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)			-1.68	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)			102,050	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			43,033	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			7.95	30.00
31.00	Percentage of Medicaid patient days (see instructions)			22.98	31.00
32.00	Sum of lines 30 and 31			30.93	32.00
33.00	Allowable disproportionate share percentage (see instructions)			14.73	33.00
34.00	Disproportionate share adjustment (see instructions)			676,753	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/26/2020 4:45 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)	1,580,435	2,110,260	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,182,078	530,448	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,712,526		
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)	21,014,589		
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)		21,057,622	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,598,820	
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).		79,638	
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)		22,736,080	
60.00	Primary payer payments		0	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,736,080	
62.00	Deductibles billed to program beneficiaries		2,000,580	
63.00	Coinurance billed to program beneficiaries		48,410	
64.00	Allowable bad debts (see instructions)		729,031	
65.00	Adjusted reimbursable bad debts (see instructions)		473,870	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		357,280	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,160,960	
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)		-14,838	
70.94	HRR adjustment amount (see instructions)		-40,627	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/26/2020 4:45 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)		21,105,495	71.00	
71.01	Sequestration adjustment (see instructions)		422,110	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		20,504,781	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)		178,604	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		647,452	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/26/2020 4:45 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13,888,587	0	13,888,587		13,888,587	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,488,947	0		4,488,947	4,488,947	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	121,874	0	121,874		121,874	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	23,852	0		23,852	23,852	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,749,540	0	5,593,458	2,156,083	7,749,541	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.010187	0.010187	0.010187	0.010187		5.00
6.00	IME payment adjustment (see instructions)	22.00	102,050	0	77,123	24,927	102,050	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	43,033	0	31,060	11,973	43,033	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	102,050	0	77,123	24,927	102,050	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	43,033	0	31,060	11,973	43,033	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1473	0.1473	0.1473	0.1473		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	676,753	0	511,447	165,306	676,753	11.00
11.01	Uncompensated care payments	36.00	1,712,526	0	1,182,078	530,448	1,712,526	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	21,014,589	0	15,781,109	5,233,480	21,014,589	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	21,057,622	0	15,812,169	5,245,453	21,057,622	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,598,820	0	1,213,414	385,406	1,598,820	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/26/2020 4:45 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	17,025,583	5,630,859	22,656,442
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,487,905	0	1,129,898	358,007	1,487,905
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	3,488	0	1,937	1,551	3,488
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0076	0.0076	0.0076	0.0076	
23.00	Indirect medical education adjustment (see instructions)	6.00	11,308	0	8,587	2,721	11,308
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0646	0.0646	0.0646	0.0646	
25.00	Disproportionate share adjustment (see instructions)	11.00	96,119	0	72,992	23,127	96,119
26.00	Total prospective capital payments (see instructions)	12.00	1,598,820	0	1,213,414	385,406	1,598,820
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/26/2020 4:45 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13,888,587	13,888,587		13,888,587	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,488,947		4,488,947	4,488,947	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	121,874	121,874		121,874	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	23,852		23,852	23,852	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,749,540	5,593,458	2,156,083	7,749,541	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.010187	0.010187	0.010187		5.00
6.00	IME payment adjustment (see instructions)	22.00	102,050	77,123	24,927	102,050	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	43,033	31,060	11,973	43,033	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	102,050	77,123	24,927	102,050	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	43,033	31,060	11,973	43,033	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1473	0.1473	0.1473		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	676,753	511,447	165,306	676,753	11.00
11.01	Uncompensated care payments	36.00	1,712,526	1,182,078	530,448	1,712,526	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	21,014,589	15,781,109	5,233,480	21,014,589	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	21,057,622	15,812,169	5,245,453	21,057,622	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,598,820	1,213,414	385,406	1,598,820	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			17,025,583	5,630,859	22,656,442	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/26/2020 4:45 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,487,905	1,129,898	358,007	1,487,905	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,488	1,937	1,551	3,488	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0076	0.0076	0.0076		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	11,308	8,587	2,721	11,308	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0646	0.0646	0.0646		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	96,119	72,992	23,127	96,119	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,598,820	1,213,414	385,406	1,598,820	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-14,838	-32,852	18,014	-14,838	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-40,627	-22,222	-18,405	-40,627	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/26/2020 4:45 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		3,515	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,113,612	2.00	
3.00	OPPS payments		5,220,895	3.00	
4.00	Outlier payment (see instructions)		3,446	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)		3,515	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		29,984	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)		29,984	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)		29,984	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		26,469	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)		3,515	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)		5,224,341	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)		1,112,123	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)		4,115,733	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		13,628	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)		4,129,361	30.00	
31.00	Primary payer payments		1,063	31.00	
32.00	Subtotal (line 30 minus line 31)		4,128,298	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)		330,402	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		214,761	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		158,917	36.00	
37.00	Subtotal (see instructions)		4,343,059	37.00	
38.00	MSP-LCC reconciliation amount from PS&R		-31	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)		4,343,090	40.00	
40.01	Sequestration adjustment (see instructions)		86,862	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		4,387,437	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)		-131,209	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)		0	93.00	
94.00	Total (sum of lines 91 and 93)		0	94.00	

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/26/2020 4:45 pm	
		Component CCN: 14-5548			
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		1,167	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00	
3.00	OPPS payments			3.00	
4.00	Outlier payment (see instructions)			4.00	
4.01	Outlier reconciliation amount (see instructions)			4.01	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		1,167	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		9,968	12.00	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00	
14.00	Total reasonable charges (sum of lines 12 and 13)		9,968	14.00	
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00	
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00	
18.00	Total customary charges (see instructions)		9,968	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,801	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)		1,167	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)		0	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)			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)		1,167	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)		1,167	30.00	
31.00	Primary payer payments			31.00	
32.00	Subtotal (line 30 minus line 31)		1,167	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)		1,167	37.00	
38.00	MSP-LCC reconciliation amount from PS&R			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)		1,167	40.00	
40.01	Sequestration adjustment (see instructions)		23	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		1,270	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)		-126	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)			90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00	
92.00	The rate used to calculate the Time Value of Money			92.00	
93.00	Time Value of Money (see instructions)			93.00	
94.00	Total (sum of lines 91 and 93)			94.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/26/2020 4:45 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		20,606,280		4,374,041	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	08/06/2019	13,396	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	08/06/2019	101,499		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)		-101,499		13,396	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)		20,504,781		4,387,437	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		178,604		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		131,209	6.02
7.00	Total Medicare program liability (see instructions)		20,683,385		4,256,228	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: 14-0251
 Component CCN: 14-5548

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 8/26/2020 4:45 pm

		Title XVIII		Skilled Nursing Facility	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				
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		4,436,598		1,270
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		4,436,598		1,270
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		126
7.00	Total Medicare program liability (see instructions)		4,436,598		1,144
				Contractor Number	NPR Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor	0			

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/26/2020 4:45 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: 14-0251 Component CCN: 14-5548	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 8/26/2020 4:45 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		4,747,041	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		4,747,041	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		219,900	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		4,527,141	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		4,527,141	15.00
15.01	Sequestration adjustment (see instructions)		90,543	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		4,436,598	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 8/26/2020 4:45 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		5,397,965		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,451,945	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5,451,945	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		8,791,664		8.00
9.00	Ancillary service charges		21,544,068	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		30,335,732	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		30,335,732	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		24,883,787	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		5,451,945	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		5,451,945	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5,451,945	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		5,451,945	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-1,596,273	0	37.00
38.00	Subtotal (line 36 ± line 37)		3,855,672	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,855,672	0	40.00
41.00	Interim payments		3,855,672	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 8/26/2020 4:45 pm
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 8/26/2020 4:45 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			1.56	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.13	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			1.25	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			2.68	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.27	6.00
7.00	Enter the lesser of line 5 or line 6			1.27	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	1.27	1.27	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	1.27	1.27	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	1.27		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.22		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	1.48		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	1.66		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	1.66		17.00
18.00	Per resident amount	103,178.14	100,231.35		18.00
19.00	Approved amount for resident costs	0	166,384	166,384	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			166,384	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	11,155	5,264		26.00
27.00	Total Inpatient Days (see instructions)	27,964	27,964		27.00
28.00	Ratio of inpatient days to total inpatient days	0.398906	0.188242		28.00
29.00	Program direct GME amount	66,372	31,320	97,692	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,426	4,426	30.00
31.00	Net Program direct GME amount			93,266	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 8/26/2020 4:45 pm
		Title XVIII	Hospital	PPS
			1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		2,292,016	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		29,904,589	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		29,904,589	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		5,118,294	42.00
43.00	Primary payer payments (see instructions)		1,063	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		5,117,231	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		35,021,820	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.853884	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.146116	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		93,266	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		79,638	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		13,628	50.00

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

Provider CCN: 14-0251

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

Worksheet G

Date/Time Prepared:
8/26/2020 4:45 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	122,696	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	170,317,799	0	0	0	4.00
5.00 Other receivable	3,126,293	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-100,623,464	0	0	0	6.00
7.00 Inventory	6,778,367	0	0	0	7.00
8.00 Prepaid expenses	449,491	0	0	0	8.00
9.00 Other current assets	2,237,656	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)	82,408,838	0	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	0	0	0	0	15.00
16.00 Accumulated depreciation	0	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	47,087,591	0	0	0	23.00
24.00 Accumulated depreciation	-5,963,881	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	41,123,710	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	123,532,548	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	34,536,502	0	0	0	37.00
38.00 Salaries, wages, and fees payable	7,527,975	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	419,791	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	21,753,742	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	64,238,010	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	37,841,217	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	8,971,127	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	46,812,344	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	111,050,354	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	12,482,194				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)	12,482,194	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	123,532,548	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0251

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

Worksheet G-1

Date/Time Prepared:
8/26/2020 4:45 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		12,487,198		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,004				2.00
3.00	Total (sum of line 1 and line 2)		12,482,194		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)		12,482,194		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)		12,482,194		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: 14-0251

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/26/2020 4:45 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	71,829,109		71,829,109	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				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	16,338,753		16,338,753	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)	88,167,862		88,167,862	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	20,459,643		20,459,643	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	20,459,643		20,459,643	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	108,627,505		108,627,505	17.00
18.00	Ancillary services	235,244,761		235,244,761	18.00
19.00	Outpatient services	0	199,631,017	199,631,017	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 REV - NET	0	3,532,993	3,532,993	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	343,872,266	203,164,010	547,036,276	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		110,366,726		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	MEDICAID ASSESSMENT TAX	6,616,404			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)		6,616,404		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		103,750,322		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0251

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

Worksheet G-3

Date/Time Prepared:
8/26/2020 4:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	547,036,276	1.00
2.00	Less contractual allowances and discounts on patients' accounts	446,991,265	2.00
3.00	Net patient revenues (line 1 minus line 2)	100,045,011	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	103,750,322	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,705,311	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	209,544	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	829	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	ACCRUE 2019 REAL ESTATE TAX CREDIT R	1,890,613	24.00
24.01	OLR 5K RUN	29,933	24.01
24.02	OTHER MISC REV	1,569,388	24.02
25.00	Total other income (sum of lines 6-24)	3,700,307	25.00
26.00	Total (line 5 plus line 25)	-5,004	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)	-5,004	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0251	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/26/2020 4:45 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,487,905	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,488	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)		76.61	3.00
4.00	Number of interns & residents (see instructions)		2.06	4.00
5.00	Indirect medical education percentage (see instructions)		0.76	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)		11,308	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		7.95	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.98	8.00
9.00	Sum of lines 7 and 8		30.93	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.46	10.00
11.00	Disproportionate share adjustment (see instructions)		96,119	11.00
12.00	Total prospective capital payments (see instructions)		1,598,820	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