

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: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/27/2020 12:39 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/27/2020	Time: 12:39 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORTHWEST COMMUNITY HOSPITAL (14-0252) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 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) JOHN SKEANS

Officer or Administrator of Provider(s)

EXECUTIVE VP/CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	170,176	236,715	0	0	1.00
2.00	Subprovider - IPF	0	137,518	-27		0	2.00
3.00	Subprovider - IRF	0	-101,233	-57		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	206,461	236,631	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: 14-0252		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 12:39 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 800 WEST CENTRAL ROAD			PO Box:				1.00		
2.00	City: ARLINGTON HEIGHTS			State: IL		Zip Code: 60005		County: COOK 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		NORTHWEST COMMUNITY HOSPITAL	140252	16974	1	07/01/1966	N	P O	3.00
4.00	Subprovider - IPF		NWCH PSYCHIATRIC UNIT	14S252	16974	4	11/01/1985	N	P O	4.00
5.00	Subprovider - IRF		NWC REHAB	14T252	16974	5	10/01/2015	N	P O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA		NORTHWEST COMMUNITY HOME CARE SERVIC	147094	16974		07/01/1966	N	P N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2018		09/30/2019		20.00
21.00	Type of Control (see instructions)					2				21.00
						1.00		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	N				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/27/2020 12:39 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	
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.	4,436	909	5	0	6,117	101	24.00
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.	81	89	0	0	149		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 OPSS 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.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 12:39 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			23.00	1	60.01	
			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
61.01	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
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet 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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	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	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 12:39 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	8,746,103	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 12:39 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y	N	145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N		146.00		
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	157.00			
158.00	SUBPROVIDER					158.00			
159.00	SNF	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00			
161.00	CMHC		N	N	N	161.00			
161.10	CORF		N	N	N	161.10			
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20			
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30			
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40			
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00	
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/27/2020 12:39 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/22/2020	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part II Date/Time Prepared: 2/27/2020 12:39 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:	HHA DATA		N	Y	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.	TONY		LEONE		41.00	
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023		TONY@LEONE-CONSULTING.COM		43.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/27/2020 12:39 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.	CONSULTANT	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: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 12:39 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	356	129,940	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)		356	129,940	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	60	21,900	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	35.00	8	2,920	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		424	154,760	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	52	18,980		0	16.00
17.00 SUBPROVIDER - IRF	41.00	33	12,045		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
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)		509				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: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 12:39 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)	32,763	2,951	70,793			1.00
2.00	HMO and other (see instructions)	9,451	7,031				2.00
3.00	HMO IPF Subprovider	0	3,298				3.00
4.00	HMO IRF Subprovider	0	149				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)	32,763	2,951	70,793			7.00
8.00	INTENSIVE CARE UNIT	4,145	242	7,206			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	NEONATAL INTENSIVE CARE UNIT	0	311	3,608			12.00
13.00	NURSERY		932	4,918			13.00
14.00	Total (see instructions)	36,908	4,436	86,525	0.00	2,585.06	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,874	1,788	14,415	0.00	90.57	16.00
17.00	SUBPROVIDER - IRF	6,058	131	8,515	0.00	41.09	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	40,388	0	60,711	0.00	66.15	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			2,343			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	2,782.87	27.00
28.00	Observation Bed Days		0	1,431			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	101	602			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: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 12:39 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	8,601	1,059	20,447	1.00
2.00 HMO and other (see instructions)			1,848	1,776		2.00
3.00 HMO IPF Subprovider				483		3.00
4.00 HMO IRF Subprovider				11		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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	8,601	1,059	20,447	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	263	223	1,945	16.00
17.00 SUBPROVIDER - IRF	0.00	0	479	11	671	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
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: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/27/2020 12:39 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	203,015,782	0	203,015,782	5,788,381.00	35.07
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		18,955,840	389,157	19,344,997	506,605.00	38.19
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		9,700,778	0	9,700,778	144,459.00	67.15
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		1,954,686	0	1,954,686	29,757.00	65.69
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
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		41,488,293	0	41,488,293		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		4,102,283	0	4,102,283		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,050,852	0	2,050,852	44,346.00	46.25
27.00	Administrative & General	5.00	37,530,166	-125,954	37,404,212	968,833.00	38.61

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/27/2020 12:39 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,279,361	0	1,279,361	11,176.00	114.47	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,571,255	0	2,571,255	72,647.00	35.39	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	3,474,951	0	3,474,951	232,288.00	14.96	32.00
33.00	Housekeeping under contract (see instructions)		936,056	0	936,056	18,721.00	50.00	33.00
34.00	Dietary	10.00	3,090,535	-1,263,166	1,827,369	106,621.00	17.14	34.00
35.00	Dietary under contract (see instructions)		1,557,098	0	1,557,098	31,142.00	50.00	35.00
36.00	Cafeteria	11.00	0	1,263,166	1,263,166	73,701.00	17.14	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	8,079,796	0	8,079,796	182,913.00	44.17	38.00
39.00	Central Services and Supply	14.00	2,891,461	0	2,891,461	120,084.00	24.08	39.00
40.00	Pharmacy	15.00	4,593,329	-371	4,592,958	99,647.00	46.09	40.00
41.00	Medical Records & Medical Records Library	16.00	1,806,040	0	1,806,040	61,821.00	29.21	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: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/27/2020 12:39 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)	206,788,297	0	206,788,297	5,849,420.00	35.35	1.00
2.00	Excluded area salaries (see instructions)	18,955,840	389,157	19,344,997	506,605.00	38.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	187,832,457	-389,157	187,443,300	5,342,815.00	35.08	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,655,464	0	11,655,464	174,216.00	66.90	4.00
5.00	Subtotal wage-related costs (see inst.)	41,488,293	0	41,488,293	0.00	22.13	5.00
6.00	Total (sum of lines 3 thru 5)	240,976,214	-389,157	240,587,057	5,517,031.00	43.61	6.00
7.00	Total overhead cost (see instructions)	69,860,900	-126,325	69,734,575	2,023,940.00	34.45	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2020 12:39 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		6,689,037	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)		648,747	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)		19,787,970	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		701,917	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		271,542	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)		509,848	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,759,085	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		14,438,987	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		292,515	19.00
20.00	State or Federal Unemployment Taxes		2,979	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		487,949	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		45,590,576	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0252

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet S-3
 Part V
 Date/Time Prepared:
 2/27/2020 12:39 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	9,700,778	45,590,576	1.00
2.00	Hospital	9,700,778	41,488,293	2.00
3.00	Subprovider - IPF	0	1,470,237	3.00
4.00	Subprovider - IRF	0	646,724	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	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
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	1,985,322	18.00

Health Financial Systems		NORTHWEST COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0252 Component CCN: 14-7094		Period: From 10/01/2018 To 09/30/2019	
				Worksheet S-4		Date/Time Prepared: 2/27/2020 12:39 pm	
				Home Health Agency I		PPS	
				1.00			
0.00 County				COOK		0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
				Total		5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,959	0	1,550	3,509	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,957.00	0.00	559.00	2,201.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	1.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.45	0.00	0.45	4.00
5.00	Other Administrative Personnel			14.13	0.00	14.13	5.00
6.00	Direct Nursing Service			24.16	0.00	24.16	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			19.51	0.00	19.51	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			4.97	0.00	4.97	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.60	0.00	0.60	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.81	0.00	0.81	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.53	0.00	1.53	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	CONTINUUM PERSONNEL			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			12			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	11180					20.00
20.01		16974					20.01
20.02		20994					20.02
20.03		22744					20.03
20.04		25540					20.04
20.05		26900					20.05
20.06		29404					20.06
20.07		34940					20.07
20.08		35380					20.08
20.09		36740					20.09
20.10		41740					20.10
20.11		99918					20.11
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	16,683	722	512	218	18,135	21.00
22.00	Skilled Nursing Visit Charges	3,103,038	134,292	95,232	40,548	3,373,110	22.00
23.00	Physical Therapy Visits	15,260	482	155	262	16,159	23.00
24.00	Physical Therapy Visit Charges	4,089,680	129,176	41,540	70,216	4,330,612	24.00
25.00	Occupational Therapy Visits	3,788	309	10	57	4,164	25.00
26.00	Occupational Therapy Visit Charges	1,015,184	82,812	2,680	15,276	1,115,952	26.00
27.00	Speech Pathology Visits	545	117	2	6	670	27.00
28.00	Speech Pathology Visit Charges	146,060	31,356	536	1,608	179,560	28.00
29.00	Medical Social Service Visits	147	10	2	5	164	29.00
30.00	Medical Social Service Visit Charges	35,721	2,430	486	1,215	39,852	30.00
31.00	Home Health Aide Visits	908	155	2	31	1,096	31.00
32.00	Home Health Aide Visit Charges	122,580	20,925	270	4,185	147,960	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	37,331	1,795	683	579	40,388	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	8,512,263	400,991	140,744	133,048	9,187,046	35.00

Health Financial Systems		NORTHWEST COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0252	Period: From 10/01/2018	Worksheet S-4	
				Component CCN: 14-7094	To 09/30/2019	Date/Time Prepared: 2/27/2020 12:39 pm	
					Home Health Agency I	PPS	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00				
36.00	Total Number of Episodes (standard/non outlier)	2,348		267	45	2,660	36.00
37.00	Total Number of Outlier Episodes		42		3	45	37.00
38.00	Total Non-Routine Medical Supply Charges	352,642	53,456	17,864	2,641	426,603	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/27/2020 12:39 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/27/2020 12:39 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-10

Date/Time Prepared:
2/27/2020 12:39 pm

				2/27/2020 12:39 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)			0.240153	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			21,091,530	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				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			137,799,166	6.00
7.00	Medicaid cost (line 1 times line 6)			33,092,883	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)			12,001,353	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)			12,001,353	19.00
				Uninsured patients	Insured patients
				1.00	2.00
				Total (col. 1 + col. 2)	
				3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)			24,869,217	1,953,392
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)			5,972,417	1,953,392
22.00	Payments received from patients for amounts previously written off as charity care			175,568	103,254
23.00	Cost of charity care (line 21 minus line 22)			5,796,849	1,850,138
				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	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			21,456,346	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			2,151,968	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			3,310,720	
28.00	Non-Medicare bad debt expense (see instructions)			18,145,626	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			5,516,479	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			13,163,466	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			25,164,819	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,653,992	14,653,992	8,890,796	23,544,788	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		20,541,903	20,541,903	0	20,541,903	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,050,852	29,011,673	31,062,525	0	31,062,525	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	37,530,166	65,623,328	103,153,494	-824,842	102,328,652	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,571,255	13,770,294	16,341,549	73,115	16,414,664	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,474,951	3,792,904	7,267,855	49,872	7,317,727	9.00
10.00	01000	DIETARY	3,090,535	3,037,719	6,128,254	-2,504,745	3,623,509	10.00
11.00	01100	CAFETERIA	0	0	0	2,504,745	2,504,745	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	8,079,796	1,053,197	9,132,993	0	9,132,993	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,891,461	1,701,670	4,593,131	847,628	5,440,759	14.00
15.00	01500	PHARMACY	4,593,329	9,915,923	14,509,252	-9,223,391	5,285,861	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,806,040	2,704,413	4,510,453	-225	4,510,228	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)	826,228	517,999	1,344,227	-916,028	428,199	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,884,474	5,759,813	37,644,287	-4,051,362	33,592,925	30.00
31.00	03100	INTENSIVE CARE UNIT	8,094,906	2,834,435	10,929,341	-1,081,293	9,848,048	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,101,209	884,628	2,985,837	-968,226	2,017,611	35.00
40.00	04000	SUBPROVIDER - IPF	6,416,832	1,436,924	7,853,756	-45,616	7,808,140	40.00
41.00	04100	SUBPROVIDER - IRF	2,625,929	3,696,916	6,322,845	-3,433,292	2,889,643	41.00
43.00	04300	NURSERY	0	0	0	2,303,670	2,303,670	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,093,525	30,786,113	43,879,638	-27,082,061	16,797,577	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,578,497	1,614,782	5,193,279	-697,750	4,495,529	52.00
53.00	05300	ANESTHESIOLOGY	22,344	634,254	656,598	-565,283	91,315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,800,620	9,096,918	23,897,538	-3,347,861	20,549,677	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,731,069	531,169	2,262,238	-67,174	2,195,064	54.01
56.01	03480	ONCOLOGY	1,923,303	9,543,110	11,466,413	-1,856	11,464,557	56.01
60.00	06000	LABORATORY	7,485,444	11,101,934	18,587,378	-790,621	17,796,757	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	489,836	1,692,363	2,182,199	-2,375	2,179,824	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,284,664	755,641	3,040,305	-340,240	2,700,065	65.00
66.00	06600	PHYSICAL THERAPY	7,676,302	1,474,648	9,150,950	-236,949	8,914,001	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	3,290,847	3,290,847	66.01
69.00	06900	ELECTROCARDIOLOGY	4,879,175	2,460,316	7,339,491	-130,939	7,208,552	69.00
69.01	03630	CARDIAC CATH LAB	2,148,867	10,501,249	12,650,116	-10,097,755	2,552,361	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	27,104,250	27,104,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,719,683	21,719,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,897,237	8,897,237	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	176,789	176,789	73.01
74.00	07400	RENAL DIALYSIS	0	1,687,009	1,687,009	-10,447	1,676,562	74.00
76.97	07697	CARDIAC REHABILITATION	791,507	106,844	898,351	-21,323	877,028	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,972,310	1,691,613	3,663,923	-322,737	3,341,186	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1,586,817	123,328	1,710,145	-751	1,709,394	90.02
91.00	09100	EMERGENCY	8,687,559	3,940,432	12,627,991	-1,792,271	10,835,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,739,129	374,741	3,113,870	-135,283	2,978,587	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	6,029,292	2,396,721	8,426,013	592	8,426,605	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		8,533,009	8,533,009	-8,533,009	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	199,958,223	279,983,925	479,942,148	-1,366,391	478,575,757	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144,324	201,372	345,696	0	345,696	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 12:39 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	
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	940,088	92,889	1,032,977	0	1,032,977	192.02
192.03	19203	MOBILE DENTAL CLINIC	220,595	78,283	298,878	0	298,878	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	883,491	883,491	192.04
194.00	07950	CORPORATE HEALTH	163,781	53,747	217,528	0	217,528	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	482,900	482,900	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	1,140,755	2,318,971	3,459,726	0	3,459,726	194.03
194.04	07954	OP PHARMACY	448,016	3,149,814	3,597,830	0	3,597,830	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	203,015,782	285,879,001	488,894,783	0	488,894,783	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 12:39 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	4,097,007	27,641,795	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-318,702	20,223,201	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	31,062,525	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-27,040,371	75,288,281	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-4,491	16,410,173	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,317,727	9.00
10.00	01000	DIETARY	-1,500	3,622,009	10.00
11.00	01100	CAFETERIA	-1,714,923	789,822	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-125,121	9,007,872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,440,759	14.00
15.00	01500	PHARMACY	0	5,285,861	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,524	4,508,704	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	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-259,210	168,989	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-314,899	33,278,026	30.00
31.00	03100	INTENSIVE CARE UNIT	-113,090	9,734,958	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	2,017,611	35.00
40.00	04000	SUBPROVIDER - IPF	-3,451	7,804,689	40.00
41.00	04100	SUBPROVIDER - IRF	0	2,889,643	41.00
43.00	04300	NURSERY	0	2,303,670	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-138,899	16,658,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-551,224	3,944,305	52.00
53.00	05300	ANESTHESIOLOGY	0	91,315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-61,370	20,488,307	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	2,195,064	54.01
56.01	03480	ONCOLOGY	-38,185	11,426,372	56.01
60.00	06000	LABORATORY	-441,935	17,354,822	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	-1,650	2,178,174	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,700,065	65.00
66.00	06600	PHYSICAL THERAPY	-3,343	8,910,658	66.00
66.01	06601	IP REHAB THERAPIES	0	3,290,847	66.01
69.00	06900	ELECTROCARDIOLOGY	-573,000	6,635,552	69.00
69.01	03630	CARDIAC CATH LAB	0	2,552,361	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	27,104,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,719,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,897,237	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	176,789	73.01
74.00	07400	RENAL DIALYSIS	0	1,676,562	74.00
76.97	07697	CARDIAC REHABILITATION	-1,216	875,812	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	3,341,186	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	1,709,394	90.02
91.00	09100	EMERGENCY	-124,654	10,711,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,978,587	92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	8,426,605	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-27,735,751	450,840,006	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	345,696	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	1,032,977	192.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.03	19203	MOBILE DENTAL CLINIC	0	298,878	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	883,491	192.04
194.00	07950	CORPORATE HEALTH	0	217,528	194.00
194.01	07951	MARKETING/COMMUNICATION	0	482,900	194.01
194.02	07952	FOUNDATION	0	0	194.02
194.03	07953	OTHER NRCC	-413,935	3,045,791	194.03
194.04	07954	OP PHARMACY	0	3,597,830	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-28,149,686	460,745,097	200.00

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 12:39 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - SHARED EXPENSES					
1.00	CAFETERIA	11.00	1,263,166	1,241,579		1.00
	TOTALS		1,263,166	1,241,579		
	B - FLOAT POOL					
1.00	INTENSIVE CARE UNIT	31.00	27,107	2,275		1.00
2.00	SUBPROVIDER - IPF	40.00	8,914	748		2.00
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	2,365	199		3.00
4.00	OPERATING ROOM	50.00	546	46		4.00
5.00	EMERGENCY	91.00	2,729	229		5.00
6.00	HOME HEALTH AGENCY	101.00	546	46		6.00
	TOTALS		42,207	3,543		
	C - TREATMENT CENTER LEASE EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	138,832		1.00
	TOTALS		0	138,832		
	D - COST OF MEDICAL SUPPLIES SOLD					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	27,951,878		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	21,719,683		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	847,628		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
	TOTALS		0	50,519,189		
	E - COST OF DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,897,237		1.00
	TOTALS		0	8,897,237		
	F - PARAMEDICAL EDUCATION					
1.00	EMS CONTINUING EDUCATION	192.04	543,037	340,454		1.00
	TOTALS		543,037	340,454		
	H - SALT CREEK OCCUPANCY COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	65,004		1.00
2.00	OPERATION OF PLANT	7.00	0	53,692		2.00
3.00	HOUSEKEEPING	9.00	0	49,872		3.00
	TOTALS		0	168,568		
	I - FLU VACCINES					
1.00	FLU VACCINE DRUGS CHG TO PATIENTS	73.01	36,818	139,971		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	TOTALS		36,818	139,971		

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
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Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
J - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	153,951	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	123,957	2.00
3.00	OPERATION OF PLANT	7.00	0	19,423	3.00
	TOTALS		0	297,331	
K - LDR COST ALLOCATION					
1.00	NURSERY	43.00	1,969,143	334,527	1.00
2.00		0.00	0	0	2.00
	TOTALS		1,969,143	334,527	
L - EMT CLINICAL EDUCATORS					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	263,417	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		263,417	0	
M - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,533,009	1.00
	TOTALS		0	8,533,009	
O - MARKETING RECLASS					
1.00	MARKETING/COMMUNICATION	194.01	125,954	356,946	1.00
	TOTALS		125,954	356,946	
P - IP REHAB THERAPY					
1.00	IP REHAB THERAPIES	66.01	0	3,290,847	1.00
	TOTALS		0	3,290,847	
500.00	Grand Total: Increases		4,243,742	74,262,033	500.00

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
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	Decreases						2/27/2020 12:39 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SHARED EXPENSES						
1.00	DIETARY	10.00	1,263,166	1,241,579	0		1.00
	TOTALS		1,263,166	1,241,579			
	B - FLOAT POOL						
1.00	ADULTS & PEDIATRICS	30.00	42,207	3,543	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		42,207	3,543			
	C - TREATMENT CENTER LEASE EXP						
1.00	OUTPATIENT TREATMENT CENTERS	90.01	0	138,832	10		1.00
	TOTALS		0	138,832			
	D - COST OF MEDICAL SUPPLIES SOLD						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	185,812	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	225	0		3.00
4.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	295,954	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,422,231	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	1,100,974	0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	206,804	0		7.00
8.00	SUBPROVIDER - IPF	40.00	0	45,703	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	142,256	0		9.00
10.00	OPERATING ROOM	50.00	0	27,064,704	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	685,911	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	565,283	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,347,861	0		13.00
14.00	OFFSITE-DIAGNOSTIC SERVICES	54.01	0	67,174	0		14.00
15.00	ONCOLOGY	56.01	0	1,836	0		15.00
16.00	LABORATORY	60.00	0	790,621	0		16.00
17.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	2,375	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	340,240	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	236,949	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	130,939	0		20.00
21.00	CARDIAC CATH LAB	69.01	0	10,097,755	0		21.00
22.00	RENAL DIALYSIS	74.00	0	10,447	0		22.00
23.00	CARDIAC REHABILITATION	76.97	0	21,323	0		23.00
24.00	OUTPATIENT TREATMENT CENTERS	90.01	0	175,074	0		24.00
25.00	PARTIAL HOSPITALIZATION PROGRAM	90.02	0	751	0		25.00
26.00	EMERGENCY	91.00	0	1,597,663	0		26.00
27.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	134,696	0		27.00
28.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	847,628	0		28.00
	TOTALS		0	50,519,189			
	E - COST OF DRUGS SOLD						
1.00	PHARMACY	15.00	0	8,897,237	0		1.00
	TOTALS		0	8,897,237			
	F - PARAMEDICAL EDUCATION						
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	543,037	340,454	0		1.00
	TOTALS		543,037	340,454			
	H - SALT CREEK OCCUPANCY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	65,004	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	53,692	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	49,872	0		3.00
	TOTALS		0	168,568			
	I - FLU VACCINES						
1.00	PHARMACY	15.00	0	139,971	0		1.00
2.00	PHARMACY	15.00	371	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	15,880	0	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	137	0	0		4.00
5.00	NEONATAL INTENSIVE CARE UNIT	35.00	1,246	0	0		5.00
6.00	SUBPROVIDER - IPF	40.00	370	0	0		6.00
7.00	SUBPROVIDER - IRF	41.00	99	0	0		7.00
8.00	OPERATING ROOM	50.00	5	0	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	63	0	0		9.00
10.00	ONCOLOGY	56.01	20	0	0		10.00
11.00	OUTPATIENT TREATMENT CENTERS	90.01	8,831	0	0		11.00
12.00	EMERGENCY	91.00	9,209	0	0		12.00
13.00	OBSERVATION BEDS (DISTINCT PART)	92.01	587	0	0		13.00

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
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	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	TOTALS		36,818	139,971		
	J - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	297,331	12	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	297,331		
	K - LDR COST ALLOCATION					
1.00	NEONATAL INTENSIVE CARE UNIT	35.00	575,926	186,814	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	1,393,217	147,713	0	2.00
	TOTALS		1,969,143	334,527		
	L - EMT CLINICAL EDUCATORS					
1.00	ADULTS & PEDIATRICS	30.00	26,571	0	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	9,564	0	0	2.00
3.00	SUBPROVIDER - IPF	40.00	9,205	0	0	3.00
4.00	OPERATING ROOM	50.00	17,944	0	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	11,776	0	0	5.00
6.00	EMERGENCY	91.00	188,357	0	0	6.00
	TOTALS		263,417	0		
	M - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	8,533,009	11	1.00
	TOTALS		0	8,533,009		
	O - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	125,954	356,946	0	1.00
	TOTALS		125,954	356,946		
	P - IP REHAB THERAPY					
1.00	SUBPROVIDER - IRF	41.00	0	3,290,847	0	1.00
	TOTALS		0	3,290,847		
500.00	Grand Total: Decreases		4,243,742	74,262,033		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/27/2020 12:39 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	89,072	0	0	0	0	1.00
2.00	Land Improvements	14,779,812	402,298	0	402,298	0	2.00
3.00	Buildings and Fixtures	314,818,704	3,890,405	0	3,890,405	3,833	3.00
4.00	Building Improvements	3,480,507	0	0	0	0	4.00
5.00	Fixed Equipment	215,331,538	1,160,551	0	1,160,551	28,521	5.00
6.00	Movable Equipment	230,280,364	22,985,438	0	22,985,438	-79,845	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	778,779,997	28,438,692	0	28,438,692	-47,491	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	778,779,997	28,438,692	0	28,438,692	-47,491	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	89,072	0				1.00
2.00	Land Improvements	15,182,110	0				2.00
3.00	Buildings and Fixtures	318,705,276	0				3.00
4.00	Building Improvements	3,480,507	0				4.00
5.00	Fixed Equipment	216,463,568	0				5.00
6.00	Movable Equipment	253,345,647	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	807,266,180	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	807,266,180	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/27/2020 12:39 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	14,653,992	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,541,903	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	35,195,895	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	14,653,992				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,541,903				2.00
3.00	Total (sum of lines 1-2)	0	35,195,895				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/27/2020 12:39 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	553,920,534	0	553,920,534	0.686168	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	253,345,646	0	253,345,646	0.313832	0	2.00
3.00	Total (sum of lines 1-2)	807,266,180	0	807,266,180	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	18,750,998	203,836	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	20,223,201	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	38,974,199	203,836	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	8,533,010	153,951	0	0	27,641,795	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	20,223,201	2.00
3.00	Total (sum of lines 1-2)	8,533,010	153,951	0	0	47,864,996	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-56,519	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,491	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,985,544			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	-1,714,923	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description			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		
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
35.00 PHO EXPENSE	A	-375	ADMINISTRATIVE & GENERAL	5.00	0	35.00
38.00 LOBBYING PORTION OF DUES	A	-53,461	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 PROVIDER ASSESSMENT REBATE	A	-22,298,211	ADMINISTRATIVE & GENERAL	5.00	0	39.00
41.14 PARAMED EDUCATION TUITION INCOM	B	-259,210	PARAMED ED PRGM-(SPECIFY)	23.00	0	41.14
41.88 PIANO DEPRECIATION	A	-1,371	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.88
42.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
42.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.01
45.01 MISC OPERATING INCOME	B	-2,696,010	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02 MISC OPERATING INCOME	B	-10,000	NURSING ADMINISTRATION	13.00	0	45.02
45.03 MISC OPERATING INCOME	B	-1,524	MEDICAL RECORDS & LIBRARY	16.00	0	45.03
45.04 MISC OPERATING INCOME	B	-61,397	ADULTS & PEDIATRICS	30.00	0	45.04
45.05 MISC OPERATING INCOME	B	-3,451	SUBPROVIDER - IPF	40.00	0	45.05
45.06 MISC OPERATING INCOME	B	-97,069	OPERATING ROOM	50.00	0	45.06
45.07 MISC OPERATING INCOME	B	-11,714	RADIOLOGY-DIAGNOSTIC	54.00	0	45.07
45.08 MISC OPERATING INCOME	B	-7,105	ONCOLOGY	56.01	0	45.08
45.09 MISC OPERATING INCOME	B	-86,713	LABORATORY	60.00	0	45.09
45.10 MISC OPERATING INCOME	B	-3,343	PHYSICAL THERAPY	66.00	0	45.10
45.11 MISC OPERATING INCOME	B	-92,709	ELECTROCARDIOLOGY	69.00	0	45.11
45.14 MISC OPERATING INCOME	B	-1,216	CARDIAC REHABILITATION	76.97	0	45.14
45.16 MISC OPERATING INCOME	B	0		0.00	0	45.16
45.17 MISC OPERATING INCOME	B	0		0.00	0	45.17
45.18 OFFSET RESEARCH COSTS	A	-115,121	NURSING ADMINISTRATION	13.00	0	45.18
45.26 NON ALLOWABLE TRAVEL	A	-35,596	ADMINISTRATIVE & GENERAL	5.00	0	45.26
45.32 CSM AND 901 DEPRECIATION	A	-460,136	CAP REL COSTS-BLDG & FIXT	1.00	9	45.32
45.33 AMORT OF DEPR EXP OF DEMOLISHED		0		0.00	0	45.33
45.35 MED VS BOOK DEP DIFF	A	4,557,142	CAP REL COSTS-BLDG & FIXT	1.00	9	45.35
45.36 MED VS BOOK DEPR DIFF	A	-317,331	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.36
46.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.00
47.00 PT B NON PHY COST	A	-1,900,000	ADMINISTRATIVE & GENERAL	5.00	0	47.00
47.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	47.01
47.02 PROFESSIONAL COMPONENT	A	-314,752	OTHER NRCC	194.03	0	47.02
47.03 OFFSET INTERCOMPANY RENT	A	1	ADMINISTRATIVE & GENERAL	5.00	0	47.03
47.04 LOSS ON EARLY ESTINGUISHMENT OF DEBT	A	1	CAP REL COSTS-BLDG & FIXT	1.00	11	47.04
47.05 OFFSET DONATIONS	A	-1,500	DIETARY	10.00	0	47.05
47.06 OFFSET DONATIONS	A	-200	ADMINISTRATIVE & GENERAL	5.00	0	47.06
47.07 OFFSET COMMUNITY SUPPORT	A	-16,550	ADULTS & PEDIATRICS	30.00	0	47.07
47.08 OFFSET COMMUNITY SUPPORT	A	-105	ONCOLOGY	56.01	0	47.08
47.09 OFFSET COMMUNITY SUPPORT	A	-99,183	OTHER NRCC	194.03	0	47.09
47.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	47.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-28,149,686				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: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/27/2020 12:39 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	ADULTS & PEDIATRICS	236,952	236,952	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	1,003,830	0	1,003,830	211,500	8,760	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	384,241	0	384,241	211,500	8,760	3.00
4.00	50.00	OPERATING ROOM	41,830	41,830	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	551,224	551,224	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	49,656	49,656	0	0	0	6.00
7.00	56.01	ONCOLOGY	68,699	0	68,699	211,500	371	7.00
8.00	60.00	LABORATORY	527,295	272,874	254,421	260,300	1,375	8.00
9.00	62.00	WHOLE BLOOD & PACKED RED BLOOD CELL	1,650	1,650	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	480,291	480,291	0	0	0	10.00
13.00	91.00	EMERGENCY	1,143,718	0	1,143,718	211,500	10,022	13.00
200.00			4,489,386	1,634,477	2,854,909		29,288	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	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	890,740	44,537	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	890,740	44,537	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	56.01	ONCOLOGY	37,724	1,886	0	0	0	7.00
8.00	60.00	LABORATORY	172,073	8,604	0	0	0	8.00
9.00	62.00	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
13.00	91.00	EMERGENCY	1,019,064	50,953	0	0	0	13.00
200.00			3,010,341	150,517	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	ADULTS & PEDIATRICS	0	0	0	236,952		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	890,740	113,090	113,090		2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	890,740	0	0		3.00
4.00	50.00	OPERATING ROOM	0	0	0	41,830		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	551,224		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	49,656		6.00
7.00	56.01	ONCOLOGY	0	37,724	30,975	30,975		7.00
8.00	60.00	LABORATORY	0	172,073	82,348	355,222		8.00
9.00	62.00	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,650		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	480,291		10.00
13.00	91.00	EMERGENCY	0	1,019,064	124,654	124,654		13.00
200.00			0	3,010,341	351,067	1,985,544		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	27,641,795	27,641,795			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	20,223,201	20,223,201			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	31,062,525	407,226	3,794	31,473,545	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,288,281	6,397,178	12,243,827	5,857,978	99,787,264
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	16,410,173	3,753,092	192,918	402,689	20,758,872
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	7,317,727	0	6,843	544,219	7,868,789
10.00	01000	DIETARY	3,622,009	331,635	61,576	286,188	4,301,408
11.00	01100	CAFETERIA	789,822	218,090	0	197,827	1,205,739
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	9,007,872	270,741	117,855	1,265,393	10,661,861
14.00	01400	CENTRAL SERVICES & SUPPLY	5,440,759	494,287	328,956	452,837	6,716,839
15.00	01500	PHARMACY	5,285,861	197,101	128,955	719,312	6,331,229
16.00	01600	MEDICAL RECORDS & LIBRARY	4,508,704	167,749	4,331	282,848	4,963,632
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)	168,989	19,276	15,375	85,605	289,245
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,278,026	3,629,032	606,362	4,762,038	42,275,458
31.00	03100	INTENSIVE CARE UNIT	9,734,958	1,023,263	161,351	1,270,485	12,190,057
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,017,611	79,334	81,060	239,053	2,417,058
40.00	04000	SUBPROVIDER - IPF	7,804,689	677,170	80,270	1,004,849	9,566,978
41.00	04100	SUBPROVIDER - IRF	2,889,643	477,639	38,942	411,236	3,817,460
43.00	04300	NURSERY	2,303,670	160,859	0	308,391	2,772,920
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,658,678	2,495,251	2,026,162	2,047,878	23,227,969
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,944,305	373,135	90,864	558,581	4,966,885
53.00	05300	ANESTHESIOLOGY	91,315	20,789	83,229	3,499	198,832
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,488,307	1,362,465	1,598,162	2,317,955	25,766,889
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	2,195,064	0	283,630	271,106	2,749,800
56.01	03480	ONCOLOGY	11,426,372	675,617	60,487	301,209	12,463,685
60.00	06000	LABORATORY	17,354,822	537,260	227,691	1,172,310	19,292,083
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,178,174	37,039	27,171	76,714	2,319,098
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,700,065	125,971	66,045	357,806	3,249,887
66.00	06600	PHYSICAL THERAPY	8,910,658	391,017	98,245	1,202,201	10,602,121
66.01	06601	IP REHAB THERAPIES	3,290,847	0	0	3,290,847	66.01
69.00	06900	ELECTROCARDIOLOGY	6,635,552	213,948	458,463	764,137	8,072,100
69.01	03630	CARDIAC CATH LAB	2,552,361	95,066	619,335	336,538	3,603,300
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,104,250	0	0	0	27,104,250
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,719,683	0	0	0	21,719,683
73.00	07300	DRUGS CHARGED TO PATIENTS	8,897,237	0	0	0	8,897,237
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	176,789	0	0	5,766	182,555
74.00	07400	RENAL DIALYSIS	1,676,562	0	69,697	0	1,746,259
76.97	07697	CARDIAC REHABILITATION	875,812	350,951	17,551	123,959	1,368,273
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							
90.01	09001	OUTPATIENT TREATMENT CENTERS	3,341,186	860,293	177,429	307,504	4,686,412
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1,709,394	193,318	0	248,515	2,151,227
91.00	09100	EMERGENCY	10,711,066	624,798	117,999	1,330,062	12,783,925
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,978,587	0	25,406	428,889	3,432,882
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	8,426,605	206,142	21,559	944,345	9,598,651
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	450,840,006	26,866,732	20,141,540	30,889,922	449,399,659

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	345,696	225,617	0	22,603	593,916 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0 192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	1,032,977	0	9,312	147,229	1,189,518 192.02
192.03	19203	MOBILE DENTAL CLINIC	298,878	0	45,429	34,548	378,855 192.03
192.04	19204	EMS CONTINUING EDUCATION	883,491	0	0	85,046	968,537 192.04
194.00	07950	CORPORATE HEALTH	217,528	108,368	7,962	25,650	359,508 194.00
194.01	07951	MARKETING/COMMUNICATION	482,900	80,290	0	19,726	582,916 194.01
194.02	07952	FOUNDATION	0	35,804	0	0	35,804 194.02
194.03	07953	OTHER NRCC	3,045,791	324,984	18,958	178,656	3,568,389 194.03
194.04	07954	OP PHARMACY	3,597,830	0	0	70,165	3,667,995 194.04
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	460,745,097	27,641,795	20,223,201	31,473,545	460,745,097 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 12:39 pm

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	99,787,264					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	5,738,811		26,497,683			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	00900	HOUSEKEEPING	2,175,335	0	0	0	10,044,124	9.00
10.00	01000	DIETARY	1,189,129	0	514,365	0	194,974	10.00
11.00	01100	CAFETERIA	333,328	0	338,257	0	128,218	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,947,482	0	419,918	0	159,173	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,856,877	0	766,637	0	290,599	14.00
15.00	01500	PHARMACY	1,750,275	0	305,704	0	115,879	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,372,201	0	260,178	0	98,622	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)	79,962	0	29,897	0	11,333	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,687,200	0	5,628,617	0	2,133,562	30.00
31.00	03100	INTENSIVE CARE UNIT	3,369,953	0	1,587,076	0	601,592	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	668,198	0	123,047	0	46,642	35.00
40.00	04000	SUBPROVIDER - IPF	2,644,801	0	1,050,288	0	398,119	40.00
41.00	04100	SUBPROVIDER - IRF	1,055,341	0	740,817	0	280,812	41.00
43.00	04300	NURSERY	766,577	0	249,492	0	94,572	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,421,395	0	3,870,124	0	1,466,996	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,373,100	0	578,730	0	219,372	52.00
53.00	05300	ANESTHESIOLOGY	54,967	0	32,244	0	12,222	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,123,282	0	2,113,178	0	801,014	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	760,185	0	0	0	0	54.01
56.01	03480	ONCOLOGY	3,445,598	0	1,047,879	0	397,206	56.01
60.00	06000	LABORATORY	5,333,316	0	833,288	0	315,863	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	641,117	0	57,447	0	21,776	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	898,435	0	195,381	0	74,060	65.00
66.00	06600	PHYSICAL THERAPY	2,930,967	0	606,465	0	229,885	66.00
66.01	06601	IP REHAB THERAPIES	909,758	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	2,231,540	0	331,833	0	125,783	69.00
69.01	03630	CARDIAC CATH LAB	996,136	0	147,447	0	55,891	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,492,997	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,004,428	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,459,650	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	50,468	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	482,755	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	378,260	0	544,324	0	206,330	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,295,563	0	1,334,310	0	505,779	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	594,709	0	299,835	0	113,655	90.02
91.00	09100	EMERGENCY	3,534,129	0	969,060	0	367,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	949,024	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	2,653,557	0	319,725	0	121,194	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,650,806	0	25,295,563	0	9,588,452	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	164,189	0	349,931	0	132,644	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	328,843	0	0	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	104,735	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

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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	
192.04	19204	EMS CONTINUING EDUCATION	267,753	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	99,386	0	168,078	0	63,711	194.00
194.01	07951	MARKETING/COMMUNICATION	161,148	0	124,530	0	47,204	194.01
194.02	07952	FOUNDATION	9,898	0	55,532	0	21,050	194.02
194.03	07953	OTHER NRCC	986,485	0	504,049	0	191,063	194.03
194.04	07954	OP PHARMACY	1,014,021	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	99,787,264	0	26,497,683	0	10,044,124	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	6,199,876					10.00
11.00	01100	CAFETERIA	0	2,005,542				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	88,650	0	14,277,084		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,199	0	0	9,689,151	14.00
15.00	01500	PHARMACY	0	48,294	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,962	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	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	6,184	0	71,757	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,365,795	445,326	0	5,167,206	0	30.00
31.00	03100	INTENSIVE CARE UNIT	220,354	96,091	0	1,114,961	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	18,072	0	209,691	0	35.00
40.00	04000	SUBPROVIDER - IPF	881,599	91,372	0	1,060,210	0	40.00
41.00	04100	SUBPROVIDER - IRF	520,764	41,422	0	480,629	0	41.00
43.00	04300	NURSERY	0	25,141	0	291,711	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	171,075	0	1,985,022	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,912	0	521,124	0	52.00
53.00	05300	ANESTHESIOLOGY	0	475	0	5,511	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	189,516	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	20,924	0	0	0	54.01
56.01	03480	ONCOLOGY	0	21,371	0	247,977	0	56.01
60.00	06000	LABORATORY	0	133,337	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,240	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	32,202	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	99,874	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	55,046	0	638,713	0	69.00
69.01	03630	CARDIAC CATH LAB	0	23,011	0	267,001	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,444,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,230,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	522	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	11,169	0	129,595	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	29,327	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	22,327	0	259,066	0	90.02
91.00	09100	EMERGENCY	0	119,225	0	1,383,391	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	38,224	0	443,519	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,988,512	1,968,490	0	14,277,084	9,675,633	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,638	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	211,364	12,620	0	0	404	192.02

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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	
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	3,199	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	6,044	0	0	121	192.04
194.00	07950	CORPORATE HEALTH	0	2,022	0	0	121	194.00
194.01	07951	MARKETING/COMMUNICATION	0	1,496	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	0	5,278	0	0	9,158	194.03
194.04	07954	OP PHARMACY	0	5,954	0	0	515	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,199,876	2,005,542	0	14,277,084	9,689,151	202.00

COST ALLOCATION - GENERAL SERVICE 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	8,551,381					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,724,595				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	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)	82	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,753	496,519	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,018	158,801	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,390	34,624	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	349	127,778	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	704	38,746	0	0	0	41.00
43.00	04300	NURSERY	0	33,692	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	83,211	557,499	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,180	51,315	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,622	48,295	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,912	1,550,269	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	484	186,859	0	0	0	54.01
56.01	03480	ONCOLOGY	3,601,790	123,799	0	0	0	56.01
60.00	06000	LABORATORY	1,309	727,847	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	63,855	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	410	124,084	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,249	164,777	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	29,113	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	78,660	215,916	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	22	211,499	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	573,950	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	290,995	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,429,967	245,294	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	54,823	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	27,141	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	49	13,790	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	78,839	50,937	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	7,058	0	0	0	90.02
91.00	09100	EMERGENCY	4,612	525,236	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	550	44,907	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,380,985	6,724,595	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	115	0	0	0	0	192.02

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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	
192.03	19203	MOBILE DENTAL CLINIC	331	0	0	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	8,433	0	0	0	0	194.03
194.04	07954	OP PHARMACY	1,161,517	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,551,381	6,724,595	0	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	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	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			488,460			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	48,643	72,264,079	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	17,490	19,358,393	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	3,521,722	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	17,490	15,838,984	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	6,976,695	0	41.00
43.00	04300	NURSERY	0	0	0	4,234,105	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	34,979	37,818,270	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	21,315	7,777,933	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	365,168	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,548,060	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	3,718,252	0	54.01
56.01	03480	ONCOLOGY	0	0	0	21,349,305	0	56.01
60.00	06000	LABORATORY	0	0	0	26,637,043	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	3,110,533	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,574,459	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,639,338	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	4,229,718	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,749,591	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	5,304,307	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40,616,010	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,245,926	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,032,148	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	288,368	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	2,256,155	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,651,790	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	7,981,167	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	3,447,877	0	90.02
91.00	09100	EMERGENCY	0	0	348,543	20,035,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	4,909,106	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	12,693,127	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	488,460	443,173,079	0	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:
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Part I
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,244,318	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	0	1,742,864	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	487,120	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	1,242,455	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	0	692,826	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	917,294	0	194.01
194.02	07952	FOUNDATION	0	0	0	122,284	0	194.02
194.03	07953	OTHER NRCC	0	0	0	5,272,855	0	194.03
194.04	07954	OP PHARMACY	0	0	0	5,850,002	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	488,460	460,745,097	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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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	72,264,079	30.00
31.00	03100	INTENSIVE CARE UNIT	19,358,393	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,521,722	35.00
40.00	04000	SUBPROVIDER - IPF	15,838,984	40.00
41.00	04100	SUBPROVIDER - IRF	6,976,695	41.00
43.00	04300	NURSERY	4,234,105	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	37,818,270	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,777,933	52.00
53.00	05300	ANESTHESIOLOGY	365,168	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,548,060	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	3,718,252	54.01
56.01	03480	ONCOLOGY	21,349,305	56.01
60.00	06000	LABORATORY	26,637,043	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,110,533	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,574,459	65.00
66.00	06600	PHYSICAL THERAPY	14,639,338	66.00
66.01	06601	IP REHAB THERAPIES	4,229,718	66.01
69.00	06900	ELECTROCARDIOLOGY	11,749,591	69.00
69.01	03630	CARDIAC CATH LAB	5,304,307	69.01
69.02	03160	CARDIAC REHABILITATION	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,616,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,245,926	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,032,148	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	288,368	73.01
74.00	07400	RENAL DIALYSIS	2,256,155	74.00
76.97	07697	CARDIAC REHABILITATION	2,651,790	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OUTPATIENT TREATMENT CENTERS	7,981,167	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	3,447,877	90.02
91.00	09100	EMERGENCY	20,035,450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,909,106	92.01
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
101.00	10100	HOME HEALTH AGENCY	12,693,127	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	443,173,079	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,244,318	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	DAY SURGERY CENTER	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	1,742,864	192.02
192.03	19203	MOBILE DENTAL CLINIC	487,120	192.03
192.04	19204	EMS CONTINUING EDUCATION	1,242,455	192.04

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Total	
			26.00	
194.00	07950	CORPORATE HEALTH	692,826	194.00
194.01	07951	MARKETING/COMMUNICATION	917,294	194.01
194.02	07952	FOUNDATION	122,284	194.02
194.03	07953	OTHER NRCC	5,272,855	194.03
194.04	07954	OP PHARMACY	5,850,002	194.04
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	460,745,097	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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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	407,226	3,794	411,020	411,020
5.00	00500	ADMINISTRATIVE & GENERAL	9,149,277	6,397,178	12,243,827	27,790,282	76,539
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	80,214	3,753,092	192,918	4,026,224	5,258
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	708	0	6,843	7,551	7,106
10.00	01000	DIETARY	22,148	331,635	61,576	415,359	3,737
11.00	01100	CAFETERIA	0	218,090	0	218,090	2,583
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	6,852	270,741	117,855	395,448	16,523
14.00	01400	CENTRAL SERVICES & SUPPLY	894,887	494,287	328,956	1,718,130	5,913
15.00	01500	PHARMACY	111,281	197,101	128,955	437,337	9,393
16.00	01600	MEDICAL RECORDS & LIBRARY	0	167,749	4,331	172,080	3,693
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	19,276	15,375	34,651	1,118
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	44,574	3,629,032	606,362	4,279,968	62,181
31.00	03100	INTENSIVE CARE UNIT	16,506	1,023,263	161,351	1,201,120	16,590
35.00	02060	NEONATAL INTENSIVE CARE UNIT	32	79,334	81,060	160,426	3,121
40.00	04000	SUBPROVIDER - IPF	27,995	677,170	80,270	785,435	13,121
41.00	04100	SUBPROVIDER - IRF	31,407	477,639	38,942	547,988	5,370
43.00	04300	NURSERY	0	160,859	0	160,859	4,027
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	212,626	2,495,251	2,026,162	4,734,039	26,741
52.00	05200	DELIVERY ROOM & LABOR ROOM	743	373,135	90,864	464,742	7,294
53.00	05300	ANESTHESIOLOGY	126	20,789	83,229	104,144	46
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,006,125	1,362,465	1,598,162	3,966,752	30,267
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	132,146	0	283,630	415,776	3,540
56.01	03480	ONCOLOGY	1,164	675,617	60,487	737,268	3,933
60.00	06000	LABORATORY	211,157	537,260	227,691	976,108	15,308
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,357	37,039	27,171	69,567	1,002
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	45,626	125,971	66,045	237,642	4,672
66.00	06600	PHYSICAL THERAPY	440,538	391,017	98,245	929,800	15,698
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	123,600	213,948	458,463	796,011	9,978
69.01	03630	CARDIAC CATH LAB	91,470	95,066	619,335	805,871	4,394
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	75
74.00	07400	RENAL DIALYSIS	0	0	69,697	69,697	0
76.97	07697	CARDIAC REHABILITATION	13,347	350,951	17,551	381,849	1,619
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT CENTERS	148,293	860,293	177,429	1,186,015	4,015
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1,299	193,318	0	194,617	3,245
91.00	09100	EMERGENCY	335,815	624,798	117,999	1,078,612	17,368
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	485	0	25,406	25,891	5,600
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	9,507	206,142	21,559	237,208	12,331
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,165,305	26,866,732	20,141,540	60,173,577	403,399
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	225,617	0	225,617	295

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	600	0	9,312	9,912	1,922	192.02
192.03	19203	MOBILE DENTAL CLINIC	6,367	0	45,429	51,796	451	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	1,111	192.04
194.00	07950	CORPORATE HEALTH	0	108,368	7,962	116,330	335	194.00
194.01	07951	MARKETING/COMMUNICATION	0	80,290	0	80,290	258	194.01
194.02	07952	FOUNDATION	0	35,804	0	35,804	0	194.02
194.03	07953	OTHER NRCC	3,390	324,984	18,958	347,332	2,333	194.03
194.04	07954	OP PHARMACY	3,841	0	0	3,841	916	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,179,503	27,641,795	20,223,201	61,044,499	411,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
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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	27,866,821					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,602,626	0	5,634,108			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	00900	HOUSEKEEPING	607,486	0	0	0	622,143	9.00
10.00	01000	DIETARY	332,077	0	109,368	0	12,077	10.00
11.00	01100	CAFETERIA	93,085	0	71,922	0	7,942	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	823,117	0	89,286	0	9,859	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	518,553	0	163,007	0	18,000	14.00
15.00	01500	PHARMACY	488,784	0	65,001	0	7,178	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	383,202	0	55,321	0	6,109	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)	22,330	0	6,357	0	702	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,263,907	0	1,196,790	0	132,155	30.00
31.00	03100	INTENSIVE CARE UNIT	941,097	0	337,454	0	37,263	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	186,602	0	26,163	0	2,889	35.00
40.00	04000	SUBPROVIDER - IPF	738,590	0	223,319	0	24,660	40.00
41.00	04100	SUBPROVIDER - IRF	294,716	0	157,517	0	17,394	41.00
43.00	04300	NURSERY	214,075	0	53,049	0	5,858	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,793,246	0	822,891	0	90,867	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	383,453	0	123,053	0	13,588	52.00
53.00	05300	ANESTHESIOLOGY	15,350	0	6,856	0	757	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,989,255	0	449,318	0	49,616	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	212,290	0	0	0	0	54.01
56.01	03480	ONCOLOGY	962,221	0	222,807	0	24,603	56.01
60.00	06000	LABORATORY	1,489,387	0	177,179	0	19,565	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	179,039	0	12,215	0	1,349	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	250,898	0	41,543	0	4,587	65.00
66.00	06600	PHYSICAL THERAPY	818,505	0	128,951	0	14,239	66.00
66.01	06601	IP REHAB THERAPIES	254,060	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	623,182	0	70,556	0	7,791	69.00
69.01	03630	CARDIAC CATH LAB	278,182	0	31,351	0	3,462	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,092,502	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,676,803	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	686,884	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	14,094	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	134,815	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	105,633	0	115,738	0	12,780	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	361,800	0	283,710	0	31,328	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	166,079	0	63,753	0	7,040	90.02
91.00	09100	EMERGENCY	986,945	0	206,048	0	22,753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	265,025	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	741,035	0	67,982	0	7,507	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,990,930	0	5,378,505	0	593,918	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,852	0	74,405	0	8,216	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	91,833	0	0	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	29,248	0	0	0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
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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	
192.04	19204	EMS CONTINUING EDUCATION	74,773	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	27,755	0	35,738	0	3,946	194.00
194.01	07951	MARKETING/COMMUNICATION	45,002	0	26,478	0	2,924	194.01
194.02	07952	FOUNDATION	2,764	0	11,808	0	1,304	194.02
194.03	07953	OTHER NRCC	275,487	0	107,174	0	11,835	194.03
194.04	07954	OP PHARMACY	283,177	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,866,821	0	5,634,108	0	622,143	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

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	872,618					10.00
11.00	01100	CAFETERIA	0	393,622				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	17,399	0	1,351,632		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,423	0	0	2,435,026	14.00
15.00	01500	PHARMACY	0	9,479	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,881	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	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	1,214	0	6,793	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	614,476	87,403	0	489,185	0	30.00
31.00	03100	INTENSIVE CARE UNIT	31,014	18,859	0	105,555	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	3,547	0	19,852	0	35.00
40.00	04000	SUBPROVIDER - IPF	124,083	17,933	0	100,372	0	40.00
41.00	04100	SUBPROVIDER - IRF	73,296	8,130	0	45,502	0	41.00
43.00	04300	NURSERY	0	4,934	0	27,617	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33,576	0	187,925	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,815	0	49,336	0	52.00
53.00	05300	ANESTHESIOLOGY	0	93	0	522	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,196	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	4,107	0	0	0	54.01
56.01	03480	ONCOLOGY	0	4,194	0	23,476	0	56.01
60.00	06000	LABORATORY	0	26,170	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,421	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,320	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,602	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	10,804	0	60,468	0	69.00
69.01	03630	CARDIAC CATH LAB	0	4,516	0	25,277	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,368,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,063,265	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	102	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	2,192	0	12,269	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	5,756	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	4,382	0	24,526	0	90.02
91.00	09100	EMERGENCY	0	23,400	0	130,968	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	7,502	0	41,989	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	842,869	386,350	0	1,351,632	2,431,630	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	714	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	29,749	2,477	0	0	101	192.02

ALLOCATION OF CAPITAL RELATED COSTS

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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	
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	804	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	1,186	0	0	30	192.04
194.00	07950	CORPORATE HEALTH	0	397	0	0	30	194.00
194.01	07951	MARKETING/COMMUNICATION	0	294	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	0	1,036	0	0	2,302	194.03
194.04	07954	OP PHARMACY	0	1,168	0	0	129	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	872,618	393,622	0	1,351,632	2,435,026	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
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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	1,017,172					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	626,286				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	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)	10	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,874	46,301	0			30.00
31.00	03100	INTENSIVE CARE UNIT	240	14,808	0			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	522	3,229	0			35.00
40.00	04000	SUBPROVIDER - IPF	41	11,916	0			40.00
41.00	04100	SUBPROVIDER - IRF	84	3,613	0			41.00
43.00	04300	NURSERY	0	3,142	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,898	51,988	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	140	4,785	0			52.00
53.00	05300	ANESTHESIOLOGY	1,501	4,504	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	465	143,769	0			54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	58	17,425	0			54.01
56.01	03480	ONCOLOGY	428,421	11,544	0			56.01
60.00	06000	LABORATORY	156	67,873	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,955	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	49	11,571	0			65.00
66.00	06600	PHYSICAL THERAPY	624	15,366	0			66.00
66.01	06601	IP REHAB THERAPIES	0	2,715	0			66.01
69.00	06900	ELECTROCARDIOLOGY	9,357	20,135	0			69.00
69.01	03630	CARDIAC CATH LAB	3	19,723	0			69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0			69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	53,522	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,136	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	407,992	22,874	0			73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	6,521	0	0			73.01
74.00	07400	RENAL DIALYSIS	0	2,531	0			74.00
76.97	07697	CARDIAC REHABILITATION	6	1,286	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	9,378	4,750	0			90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	658	0			90.02
91.00	09100	EMERGENCY	549	48,979	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	65	4,188	0			92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	877,954	626,286	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	DAY SURGERY CENTER	0	0	0			192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	14	0	0			192.02

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	
192.03	19203	MOBILE DENTAL CLINIC	39	0	0			192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0			192.04
194.00	07950	CORPORATE HEALTH	0	0	0			194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0			194.01
194.02	07952	FOUNDATION	0	0	0			194.02
194.03	07953	OTHER NRCC	1,003	0	0			194.03
194.04	07954	OP PHARMACY	138,162	0	0			194.04
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)	1,017,172	626,286	0	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & 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		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			73,175			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				10,174,240	0	30.00
31.00	03100	INTENSIVE CARE UNIT				2,704,000	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				406,351	0	35.00
40.00	04000	SUBPROVIDER - IPF				2,039,470	0	40.00
41.00	04100	SUBPROVIDER - IRF				1,153,610	0	41.00
43.00	04300	NURSERY				473,561	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				7,751,171	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				1,055,206	0	52.00
53.00	05300	ANESTHESIOLOGY				133,773	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				6,666,638	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES				653,196	0	54.01
56.01	03480	ONCOLOGY				2,418,467	0	56.01
60.00	06000	LABORATORY				2,771,746	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				270,548	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				557,282	0	65.00
66.00	06600	PHYSICAL THERAPY				1,942,785	0	66.00
66.01	06601	IP REHAB THERAPIES				256,775	0	66.01
69.00	06900	ELECTROCARDIOLOGY				1,608,282	0	69.00
69.01	03630	CARDIAC CATH LAB				1,172,779	0	69.01
69.02	03160	CARDIAC REHABILITATION				0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				3,514,389	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				2,767,204	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				1,117,750	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS				20,792	0	73.01
74.00	07400	RENAL DIALYSIS				207,043	0	74.00
76.97	07697	CARDIAC REHABILITATION				633,372	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS				1,886,752	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM				464,300	0	90.02
91.00	09100	EMERGENCY				2,515,622	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)				350,260	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
101.00	10100	HOME HEALTH AGENCY				1,066,063	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	58,753,427	0	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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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	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				355,099	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				0	0	192.00
192.01	19201	DAY SURGERY CENTER				0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER				136,008	0	192.02
192.03	19203	MOBILE DENTAL CLINIC				82,338	0	192.03
192.04	19204	EMS CONTINUING EDUCATION				77,100	0	192.04
194.00	07950	CORPORATE HEALTH				184,531	0	194.00
194.01	07951	MARKETING/COMMUNICATION				155,246	0	194.01
194.02	07952	FOUNDATION				51,680	0	194.02
194.03	07953	OTHER NRCC				748,502	0	194.03
194.04	07954	OP PHARMACY				427,393	0	194.04
200.00		Cross Foot Adjustments	0	0	73,175	73,175	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	73,175	61,044,499	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
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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	10,174,240	30.00
31.00	03100	INTENSIVE CARE UNIT	2,704,000	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	406,351	35.00
40.00	04000	SUBPROVIDER - IPF	2,039,470	40.00
41.00	04100	SUBPROVIDER - IRF	1,153,610	41.00
43.00	04300	NURSERY	473,561	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	7,751,171	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,055,206	52.00
53.00	05300	ANESTHESIOLOGY	133,773	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,666,638	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	653,196	54.01
56.01	03480	ONCOLOGY	2,418,467	56.01
60.00	06000	LABORATORY	2,771,746	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	270,548	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	557,282	65.00
66.00	06600	PHYSICAL THERAPY	1,942,785	66.00
66.01	06601	IP REHAB THERAPIES	256,775	66.01
69.00	06900	ELECTROCARDIOLOGY	1,608,282	69.00
69.01	03630	CARDIAC CATH LAB	1,172,779	69.01
69.02	03160	CARDIAC REHABILITATION	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,514,389	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,767,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,117,750	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	20,792	73.01
74.00	07400	RENAL DIALYSIS	207,043	74.00
76.97	07697	CARDIAC REHABILITATION	633,372	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,886,752	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	464,300	90.02
91.00	09100	EMERGENCY	2,515,622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	350,260	92.01
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,066,063	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,753,427	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355,099	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	DAY SURGERY CENTER	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	136,008	192.02
192.03	19203	MOBILE DENTAL CLINIC	82,338	192.03
192.04	19204	EMS CONTINUING EDUCATION	77,100	192.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			Total	
			26.00	
194.00	07950	CORPORATE HEALTH	184,531	194.00
194.01	07951	MARKETING/COMMUNICATION	155,246	194.01
194.02	07952	FOUNDATION	51,680	194.02
194.03	07953	OTHER NRCC	748,502	194.03
194.04	07954	OP PHARMACY	427,393	194.04
200.00		Cross Foot Adjustments	73,175	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	61,044,499	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	694,055					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		20,160,426				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,225	3,782	200,964,930			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	160,626	12,205,821	37,404,212	-99,787,264	360,957,833	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	94,236	192,319	2,571,255	0	20,758,872	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,822	3,474,951	0	7,868,789	9.00
10.00	01000	DIETARY	8,327	61,385	1,827,369	0	4,301,408	10.00
11.00	01100	CAFETERIA	5,476	0	1,263,166	0	1,205,739	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,798	117,489	8,079,796	0	10,661,861	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,411	327,935	2,891,461	0	6,716,839	14.00
15.00	01500	PHARMACY	4,949	128,555	4,592,958	0	6,331,229	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,212	4,318	1,806,040	0	4,963,632	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)	484	15,327	546,608	0	289,245	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91,121	604,480	30,406,599	0	42,275,458	30.00
31.00	03100	INTENSIVE CARE UNIT	25,693	160,850	8,112,312	0	12,190,057	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,992	80,808	1,526,402	0	2,417,058	35.00
40.00	04000	SUBPROVIDER - IPF	17,003	80,021	6,416,171	0	9,566,978	40.00
41.00	04100	SUBPROVIDER - IRF	11,993	38,821	2,625,830	0	3,817,460	41.00
43.00	04300	NURSERY	4,039	0	1,969,143	0	2,772,920	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,653	2,019,872	13,076,122	0	23,227,969	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,369	90,582	3,566,658	0	4,966,885	52.00
53.00	05300	ANESTHESIOLOGY	522	82,971	22,344	0	198,832	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,210	1,593,201	14,800,620	0	25,766,889	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	282,750	1,731,069	0	2,749,800	54.01
56.01	03480	ONCOLOGY	16,964	60,299	1,923,283	0	12,463,685	56.01
60.00	06000	LABORATORY	13,490	226,984	7,485,444	0	19,292,083	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	930	27,087	489,836	0	2,319,098	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,163	65,840	2,284,664	0	3,249,887	65.00
66.00	06600	PHYSICAL THERAPY	9,818	97,940	7,676,302	0	10,602,121	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	3,290,847	66.01
69.00	06900	ELECTROCARDIOLOGY	5,372	457,040	4,879,175	0	8,072,100	69.00
69.01	03630	CARDIAC CATH LAB	2,387	617,412	2,148,867	0	3,603,300	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	27,104,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	21,719,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,897,237	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	36,818	0	182,555	73.01
74.00	07400	RENAL DIALYSIS	0	69,481	0	0	1,746,259	74.00
76.97	07697	CARDIAC REHABILITATION	8,812	17,497	791,507	0	1,368,273	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	21,601	176,878	1,963,479	0	4,686,412	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	4,854	0	1,586,817	0	2,151,227	90.02
91.00	09100	EMERGENCY	15,688	117,633	8,492,722	0	12,783,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	25,327	2,738,542	0	3,432,882	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	5,176	21,492	6,029,838	0	9,598,651	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	674,594	20,079,019	197,238,380	-99,787,264	349,612,395	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,665	0	144,324	0	593,916	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	9,283	940,088	0	1,189,518	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	45,288	220,595	0	378,855	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	543,037	0	968,537	192.04
194.00	07950	CORPORATE HEALTH	2,721	7,937	163,781	0	359,508	194.00
194.01	07951	MARKETING/COMMUNICATION	2,016	0	125,954	0	582,916	194.01
194.02	07952	FOUNDATION	899	0	0	0	35,804	194.02
194.03	07953	OTHER NRCC	8,160	18,899	1,140,755	0	3,568,389	194.03
194.04	07954	OP PHARMACY	0	0	448,016	0	3,667,995	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	27,641,795	20,223,201	31,473,545		99,787,264	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.826520	1.003114	0.156612		0.276451	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			411,020		27,866,821	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002045		0.077202	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: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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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	428,968				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	0	0	428,968		9.00
10.00	01000	DIETARY	0	8,327	0	8,327	304,122	10.00
11.00	01100	CAFETERIA	0	5,476	0	5,476	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	6,798	0	6,798	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,411	0	12,411	0	14.00
15.00	01500	PHARMACY	0	4,949	0	4,949	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,212	0	4,212	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	484	0	484	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	91,121	0	91,121	214,155	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,693	0	25,693	10,809	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	1,992	0	1,992	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	17,003	0	17,003	43,245	40.00
41.00	04100	SUBPROVIDER - IRF	0	11,993	0	11,993	25,545	41.00
43.00	04300	NURSERY	0	4,039	0	4,039	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	62,653	0	62,653	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,369	0	9,369	0	52.00
53.00	05300	ANESTHESIOLOGY	0	522	0	522	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,210	0	34,210	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0	16,964	0	16,964	0	56.01
60.00	06000	LABORATORY	0	13,490	0	13,490	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	930	0	930	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,163	0	3,163	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,818	0	9,818	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	5,372	0	5,372	0	69.00
69.01	03630	CARDIAC CATH LAB	0	2,387	0	2,387	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	8,812	0	8,812	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	21,601	0	21,601	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	4,854	0	4,854	0	90.02
91.00	09100	EMERGENCY	0	15,688	0	15,688	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	5,176	0	5,176	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	409,507	0	409,507	293,754	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,665	0	5,665	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:39 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	
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	0	0	10,368	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	2,721	0	2,721	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	2,016	0	2,016	0	194.01
194.02	07952	FOUNDATION	0	899	0	899	0	194.02
194.03	07953	OTHER NRCC	0	8,160	0	8,160	0	194.03
194.04	07954	OP PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	26,497,683	0	10,044,124	6,199,876	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	61.770768	0.000000	23.414623	20.386148	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	5,634,108	0	622,143	872,618	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	13.134099	0.000000	1.450325	2.869302	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: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description			CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (FTE'S NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISTION)	
			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	4,138,080					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	182,913	0	2,538,797			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,084	0	0	49,740,957		14.00
15.00	01500	PHARMACY	99,647	0	0	0	21,833,046	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,821	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	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	12,760	0	12,760	0	210	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	918,849	0	918,849	0	40,220	30.00
31.00	03100	INTENSIVE CARE UNIT	198,266	0	198,266	0	5,153	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	37,288	0	37,288	0	11,208	35.00
40.00	04000	SUBPROVIDER - IPF	188,530	0	188,530	0	890	40.00
41.00	04100	SUBPROVIDER - IRF	85,467	0	85,467	0	1,798	41.00
43.00	04300	NURSERY	51,873	0	51,873	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	352,983	0	352,983	0	212,450	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,668	0	92,668	0	3,012	52.00
53.00	05300	ANESTHESIOLOGY	980	0	980	0	32,226	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	391,032	0	0	0	9,989	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	43,174	0	0	0	1,237	54.01
56.01	03480	ONCOLOGY	44,096	0	44,096	0	9,195,938	56.01
60.00	06000	LABORATORY	275,118	0	0	0	3,342	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,938	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	66,444	0	0	0	1,048	65.00
66.00	06600	PHYSICAL THERAPY	206,072	0	0	0	13,401	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	113,578	0	113,578	0	200,831	69.00
69.01	03630	CARDIAC CATH LAB	47,479	0	47,479	0	56	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	27,951,878	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,719,683	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,757,265	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	1,077	0	0	0	139,971	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	23,045	0	23,045	0	124	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	60,512	0	0	0	201,289	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	46,068	0	46,068	0	0	90.02
91.00	09100	EMERGENCY	245,999	0	245,999	0	11,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	78,868	0	78,868	0	1,403	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,061,629	0	2,538,797	49,671,561	18,844,835	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,507	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description			CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (FTE'S NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISTION)	
			11.00	12.00	13.00	14.00	15.00	
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	26,040	0	0	2,072	294	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	16,422	845	192.03
192.04	19204	EMS CONTINUING EDUCATION	12,471	0	0	622	0	192.04
194.00	07950	CORPORATE HEALTH	4,173	0	0	622	0	194.00
194.01	07951	MARKETING/COMMUNICATION	3,086	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	10,890	0	0	47,015	21,530	194.03
194.04	07954	OP PHARMACY	12,284	0	0	2,643	2,965,542	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,005,542	0	14,277,084	9,689,151	8,551,381	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.484655	0.000000	5.623563	0.194792	0.391671	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	393,622	0	1,351,632	2,435,026	1,017,172	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.095122	0.000000	0.532391	0.048954	0.046589	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: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	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	1,786,605,000					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			0	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	131,912,639	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	42,189,331	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	9,198,775	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	33,947,359	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	10,293,847	0	0	0	0	41.00
43.00	04300	NURSERY	8,951,163	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	148,113,516	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,633,093	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,830,824	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	411,916,877	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	49,643,641	0	0	0	0	54.01
56.01	03480	ONCOLOGY	32,890,237	0	0	0	0	56.01
60.00	06000	LABORATORY	193,370,549	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,964,664	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	32,965,951	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	43,777,041	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	7,734,471	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	57,363,508	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	56,189,854	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	152,484,126	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,310,153	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,168,419	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	7,210,679	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	3,663,625	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	13,532,558	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1,875,263	0	0	0	0	90.02
91.00	09100	EMERGENCY	139,542,089	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	11,930,748	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,786,605,000	0	0	0	0	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	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		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	0	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	0	0	0	0	0	194.03
194.04	07954	OP PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,724,595	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003764	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	626,286	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000351	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: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:39 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	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		6,256	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	623	30.00
31.00	03100	INTENSIVE CARE UNIT	0	224	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	224	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	273	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	54.01
56.01	03480	ONCOLOGY	0	0	56.01
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	73.01
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					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	90.02
91.00	09100	EMERGENCY	0	4,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,256	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet B-1
Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	194.01
194.02	07952	FOUNDATION	0	0	194.02
194.03	07953	OTHER NRCC	0	0	194.03
194.04	07954	OP PHARMACY	0	0	194.04
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	488,460	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	78.078645	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	73,175	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	11.696771	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: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 12:39 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	72,264,079		72,264,079		0	72,264,079	30.00
31.00	03100	INTENSIVE CARE UNIT	19,358,393		19,358,393		113,090	19,471,483	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,521,722		3,521,722		0	3,521,722	35.00
40.00	04000	SUBPROVIDER - IPF	15,838,984		15,838,984		0	15,838,984	40.00
41.00	04100	SUBPROVIDER - IRF	6,976,695		6,976,695		0	6,976,695	41.00
43.00	04300	NURSERY	4,234,105		4,234,105		0	4,234,105	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	37,818,270		37,818,270		0	37,818,270	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,777,933		7,777,933		0	7,777,933	52.00
53.00	05300	ANESTHESIOLOGY	365,168		365,168		0	365,168	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,548,060		37,548,060		0	37,548,060	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	3,718,252		3,718,252		0	3,718,252	54.01
56.01	03480	ONCOLOGY	21,349,305		21,349,305		30,975	21,380,280	56.01
60.00	06000	LABORATORY	26,637,043		26,637,043		82,348	26,719,391	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,110,533		3,110,533		0	3,110,533	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0		0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,574,459	0	4,574,459		0	4,574,459	65.00
66.00	06600	PHYSICAL THERAPY	14,639,338	0	14,639,338		0	14,639,338	66.00
66.01	06601	IP REHAB THERAPIES	4,229,718	0	4,229,718		0	4,229,718	66.01
69.00	06900	ELECTROCARDIOLOGY	11,749,591		11,749,591		0	11,749,591	69.00
69.01	03630	CARDIAC CATH LAB	5,304,307		5,304,307		0	5,304,307	69.01
69.02	03160	CARDIAC REHABILITATION	0		0		0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,616,010		40,616,010		0	40,616,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,245,926		32,245,926		0	32,245,926	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,032,148		15,032,148		0	15,032,148	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	288,368		288,368		0	288,368	73.01
74.00	07400	RENAL DIALYSIS	2,256,155		2,256,155		0	2,256,155	74.00
76.97	07697	CARDIAC REHABILITATION	2,651,790		2,651,790		0	2,651,790	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS	7,981,167		7,981,167		0	7,981,167	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	3,447,877		3,447,877		0	3,447,877	90.02
91.00	09100	EMERGENCY	20,035,450		20,035,450		124,654	20,160,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,431,787		1,431,787		0	1,431,787	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,909,106		4,909,106		0	4,909,106	92.01
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0		0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	0	99.40
101.00	10100	HOME HEALTH AGENCY	12,693,127		12,693,127		0	12,693,127	101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	444,604,866	0	444,604,866		351,067	444,955,933	200.00
201.00		Less Observation Beds	1,431,787		1,431,787			1,431,787	201.00
202.00		Total (see instructions)	443,173,079	0	443,173,079		351,067	443,524,146	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 12:39 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	136,256,936		136,256,936		30.00
31.00	03100	INTENSIVE CARE UNIT	38,660,576		38,660,576		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	7,698,496		7,698,496		35.00
40.00	04000	SUBPROVIDER - IPF	34,371,017		34,371,017		40.00
41.00	04100	SUBPROVIDER - IRF	14,877,027		14,877,027		41.00
43.00	04300	NURSERY	10,164,215		10,164,215		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,168,744	100,630,520	153,799,264	0.245894	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,649,963	846,475	13,496,438	0.576295	0.000000
53.00	05300	ANESTHESIOLOGY	6,740,353	6,986,992	13,727,345	0.026602	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,563,792	308,952,032	418,515,824	0.089717	0.000000
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	450,343	51,808,746	52,259,089	0.071150	0.000000
56.01	03480	ONCOLOGY	205,105	30,997,441	31,202,546	0.684217	0.000000
60.00	06000	LABORATORY	84,760,649	112,663,802	197,424,451	0.134923	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,874,040	4,361,439	15,235,479	0.204164	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	27,759,234	2,063,943	29,823,177	0.153386	0.000000
66.00	06600	PHYSICAL THERAPY	8,887,208	36,015,910	44,903,118	0.326021	0.000000
66.01	06601	IP REHAB THERAPIES	11,269,892	0	11,269,892	0.375311	0.000000
69.00	06900	ELECTROCARDIOLOGY	13,697,078	42,282,681	55,979,759	0.209890	0.000000
69.01	03630	CARDIAC CATH LAB	27,822,576	36,117,076	63,939,652	0.082958	0.000000
69.02	03160	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	85,922,708	76,192,766	162,115,474	0.250538	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,579,336	32,885,025	82,464,361	0.391029	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	49,974,705	11,533,726	61,508,431	0.244392	0.000000
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	293,311	438,947	732,258	0.393807	0.000000
74.00	07400	RENAL DIALYSIS	5,723,058	632,348	6,355,406	0.354998	0.000000
76.97	07697	CARDIAC REHABILITATION	3,481	4,114,928	4,118,409	0.643887	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT TREATMENT CENTERS	83,302	15,571,490	15,654,792	0.509823	0.000000
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	137,455	2,787,375	2,924,830	1.178830	0.000000
91.00	09100	EMERGENCY	48,730,950	91,923,978	140,654,928	0.142444	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	622,900	1,450,651	2,073,551	0.690500	0.000000
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,431,432	9,150,900	11,582,332	0.423844	0.000000
	OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
101.00	10100	HOME HEALTH AGENCY	0	11,588,453	11,588,453		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	853,379,882	991,997,644	1,845,377,526		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	853,379,882	991,997,644	1,845,377,526		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Prepared: 2/27/2020 12:39 pm
			Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio			
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.245894		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.576295		52.00
53.00	05300	ANESTHESIOLOGY	0.026602		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089717		54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.071150		54.01
56.01	03480	ONCOLOGY	0.685209		56.01
60.00	06000	LABORATORY	0.135340		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.204164		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.153386		65.00
66.00	06600	PHYSICAL THERAPY	0.326021		66.00
66.01	06601	IP REHAB THERAPIES	0.375311		66.01
69.00	06900	ELECTROCARDIOLOGY	0.209890		69.00
69.01	03630	CARDIAC CATH LAB	0.082958		69.01
69.02	03160	CARDIAC REHABILITATION	0.000000		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.250538		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391029		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244392		73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.393807		73.01
74.00	07400	RENAL DIALYSIS	0.354998		74.00
76.97	07697	CARDIAC REHABILITATION	0.643887		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.509823		90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1.178830		90.02
91.00	09100	EMERGENCY	0.143330		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.690500		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.423844		92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 12:39 pm

			Title XIX		Hospital		Cost
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	72,264,079		72,264,079	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	19,358,393		19,358,393	0	0 31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,521,722		3,521,722	0	0 35.00
40.00	04000	SUBPROVIDER - IPF	15,838,984		15,838,984	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	6,976,695		6,976,695	0	0 41.00
43.00	04300	NURSERY	4,234,105		4,234,105	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,818,270		37,818,270	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,777,933		7,777,933	0	0 52.00
53.00	05300	ANESTHESIOLOGY	365,168		365,168	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,548,060		37,548,060	0	0 54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	3,718,252		3,718,252	0	0 54.01
56.01	03480	ONCOLOGY	21,349,305		21,349,305	0	0 56.01
60.00	06000	LABORATORY	26,637,043		26,637,043	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,110,533		3,110,533	0	0 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	4,574,459	0	4,574,459	0	0 65.00
66.00	06600	PHYSICAL THERAPY	14,639,338	0	14,639,338	0	0 66.00
66.01	06601	IP REHAB THERAPIES	4,229,718	0	4,229,718	0	0 66.01
69.00	06900	ELECTROCARDIOLOGY	11,749,591		11,749,591	0	0 69.00
69.01	03630	CARDIAC CATH LAB	5,304,307		5,304,307	0	0 69.01
69.02	03160	CARDIAC REHABILITATION	0		0	0	0 69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,616,010		40,616,010	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,245,926		32,245,926	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,032,148		15,032,148	0	0 73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	288,368		288,368	0	0 73.01
74.00	07400	RENAL DIALYSIS	2,256,155		2,256,155	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	2,651,790		2,651,790	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							
90.01	09001	OUTPATIENT TREATMENT CENTERS	7,981,167		7,981,167	0	0 90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	3,447,877		3,447,877	0	0 90.02
91.00	09100	EMERGENCY	20,035,450		20,035,450	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,431,787		1,431,787	0	0 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,909,106		4,909,106	0	0 92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0		0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0 99.40
101.00	10100	HOME HEALTH AGENCY	12,693,127		12,693,127		0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	444,604,866	0	444,604,866	0	0 200.00
201.00		Less Observation Beds	1,431,787		1,431,787		0 201.00
202.00		Total (see instructions)	443,173,079	0	443,173,079	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 12:39 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	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0		0			35.00	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
41.00	04100	SUBPROVIDER - IRF	0		0			41.00	
43.00	04300	NURSERY	0		0			43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0.000000	0.000000	54.01	
56.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	56.01	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
66.01	06601	IP REHAB THERAPIES	0	0	0	0.000000	0.000000	66.01	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
69.01	03630	CARDIAC CATH LAB	0	0	0	0.000000	0.000000	69.01	
69.02	03160	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	69.02	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0.000000	0.000000	73.01	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0.000000	0.000000	90.01	
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	90.02	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Prepared: 2/27/2020 12:39 pm
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000		54.01
56.01	03480	ONCOLOGY	0.000000		56.01
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
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
66.01	06601	IP REHAB THERAPIES	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03630	CARDIAC CATH LAB	0.000000		69.01
69.02	03160	CARDIAC REHABILITATION	0.000000		69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000		73.01
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					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000		90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/27/2020 12:39 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	10,174,240	0	10,174,240	72,224	140.87	30.00
31.00	INTENSIVE CARE UNIT	2,704,000		2,704,000	7,206	375.24	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	406,351		406,351	3,608	112.63	35.00
40.00	SUBPROVIDER - IPF	2,039,470	0	2,039,470	14,415	141.48	40.00
41.00	SUBPROVIDER - IRF	1,153,610	0	1,153,610	8,515	135.48	41.00
43.00	NURSERY	473,561		473,561	4,918	96.29	43.00
200.00	Total (lines 30 through 199)	16,951,232		16,951,232	110,886		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	32,763	4,615,324				30.00
31.00	INTENSIVE CARE UNIT	4,145	1,555,370				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00	SUBPROVIDER - IPF	2,874	406,614				40.00
41.00	SUBPROVIDER - IRF	6,058	820,738				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	45,840	7,398,046				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/27/2020 12:39 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	7,751,171	153,799,264	0.050398	24,412,125	1,230,322	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,055,206	13,496,438	0.078184	3,847	301	52.00
53.00	05300	ANESTHESIOLOGY	133,773	13,727,345	0.009745	3,042,017	29,644	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,666,638	418,515,824	0.015929	50,336,898	801,816	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	653,196	52,259,089	0.012499	200,141	2,502	54.01
56.01	03480	ONCOLOGY	2,418,467	31,202,546	0.077509	188,422	14,604	56.01
60.00	06000	LABORATORY	2,771,746	197,424,451	0.014040	37,816,238	530,940	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	270,548	15,235,479	0.017758	5,006,193	88,900	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	557,282	29,823,177	0.018686	14,295,645	267,128	65.00
66.00	06600	PHYSICAL THERAPY	1,942,785	44,903,118	0.043266	4,945,344	213,965	66.00
66.01	06601	IP REHAB THERAPIES	256,775	11,269,892	0.022784	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	1,608,282	55,979,759	0.028730	7,165,883	205,876	69.00
69.01	03630	CARDIAC CATH LAB	1,172,779	63,939,652	0.018342	14,538,350	266,662	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,514,389	162,115,474	0.021678	38,659,243	838,055	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,767,204	82,464,361	0.033556	26,243,718	880,634	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,117,750	61,508,431	0.018172	22,785,548	414,059	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	20,792	732,258	0.028394	0	0	73.01
74.00	07400	RENAL DIALYSIS	207,043	6,355,406	0.032577	2,989,990	97,405	74.00
76.97	07697	CARDIAC REHABILITATION	633,372	4,118,409	0.153790	3,443	529	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,886,752	15,654,792	0.120522	37,213	4,485	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	464,300	2,924,830	0.158744	10,200	1,619	90.02
91.00	09100	EMERGENCY	2,515,622	140,654,928	0.017885	23,880,152	427,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	201,584	2,073,551	0.097217	165,049	16,046	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	350,260	11,582,332	0.030241	1,317,726	39,849	92.01
200.00		Total (lines 50 through 199)	40,937,716	1,591,760,806		278,043,385	6,372,438	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/27/2020 12:39 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	48,643	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	0	17,490	0	31.00			
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	17,490	0	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00			
43.00	04300	NURSERY	0	0	0	0	0	43.00			
200.00		Total (lines 30 through 199)	0	0	0	83,623	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	48,643	72,224	0.67	32,763	30.00			
31.00	03100	INTENSIVE CARE UNIT		17,490	7,206	2.43	4,145	31.00			
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	3,608	0.00	0	35.00			
40.00	04000	SUBPROVIDER - IPF	0	17,490	14,415	1.21	2,874	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	8,515	0.00	6,058	41.00			
43.00	04300	NURSERY		0	4,918	0.00	0	43.00			
200.00		Total (lines 30 through 199)		83,623	110,886		45,840	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	21,951								30.00
31.00	03100	INTENSIVE CARE UNIT	10,072								31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0								35.00
40.00	04000	SUBPROVIDER - IPF	3,478								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	35,501								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	34,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	21,315	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	348,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	964	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	405,801	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 12:39 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	34,979	34,979	153,799,264	0.000227	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,315	21,315	13,496,438	0.001579	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,727,345	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	418,515,824	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	52,259,089	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	31,202,546	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	197,424,451	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	15,235,479	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,823,177	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	44,903,118	0.000000	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	11,269,892	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	55,979,759	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	63,939,652	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	162,115,474	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	82,464,361	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,508,431	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	732,258	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	6,355,406	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	4,118,409	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	15,654,792	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	2,924,830	0.000000	90.02
91.00	09100	EMERGENCY	0	348,543	348,543	140,654,928	0.002478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	964	964	2,073,551	0.000465	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	11,582,332	0.000000	92.01
200.00		Total (lines 50 through 199)	0	405,801	405,801	1,591,760,806		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 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)	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000227	24,412,125	5,542	30,087,063	6,830	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.001579	3,847	6	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,042,017	0	2,167,850	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	50,336,898	0	103,755,604	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	200,141	0	16,683,075	0	54.01
56.01	03480	ONCOLOGY	0.000000	188,422	0	16,515,205	0	56.01
60.00	06000	LABORATORY	0.000000	37,816,238	0	16,132,519	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	5,006,193	0	1,882,763	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	14,295,645	0	615,021	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,945,344	0	1,252,868	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,165,883	0	16,171,043	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	14,538,350	0	17,433,562	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	38,659,243	0	25,142,138	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	26,243,718	0	15,796,842	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	22,785,548	0	3,464,184	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	85,838	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	2,989,990	0	355,532	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	3,443	0	1,974,212	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	37,213	0	1,694,632	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	10,200	0	79,077	0	90.02
91.00	09100	EMERGENCY	0.002478	23,880,152	59,175	20,409,981	50,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000465	165,049	77	299,543	139	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	1,317,726	0	3,289,536	0	92.01
200.00		Total (lines 50 through 199)		278,043,385	64,800	295,288,088	57,545	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 12:39 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	0.245894	30,087,063	0	13	7,398,228	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.576295	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.026602	2,167,850	0	0	57,669	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089717	103,755,604	0	8,286	9,308,642	54.00	
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.071150	16,683,075	0	1,854	1,187,001	54.01	
56.01	03480	ONCOLOGY	0.684217	16,515,205	0	26,086	11,299,984	56.01	
60.00	06000	LABORATORY	0.134923	16,132,519	0	0	2,176,648	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.204164	1,882,763	0	0	384,392	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.153386	615,021	0	0	94,336	65.00	
66.00	06600	PHYSICAL THERAPY	0.326021	1,252,868	0	17	408,461	66.00	
66.01	06601	IP REHAB THERAPIES	0.375311	0	0	0	0	66.01	
69.00	06900	ELECTROCARDIOLOGY	0.209890	16,171,043	0	119	3,394,140	69.00	
69.01	03630	CARDIAC CATH LAB	0.082958	17,433,562	0	659	1,446,253	69.01	
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.250538	25,142,138	0	29	6,299,061	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391029	15,796,842	0	0	6,177,023	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244392	3,464,184	0	5,670	846,619	73.00	
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.393807	85,838	0	3,620	33,804	73.01	
74.00	07400	RENAL DIALYSIS	0.354998	355,532	0	0	126,213	74.00	
76.97	07697	CARDIAC REHABILITATION	0.643887	1,974,212	0	0	1,271,169	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.509823	1,694,632	0	0	863,962	90.01	
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1.178830	79,077	0	0	93,218	90.02	
91.00	09100	EMERGENCY	0.142444	20,409,981	0	0	2,907,279	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.690500	299,543	0	0	206,834	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.423844	3,289,536	0	0	1,394,250	92.01	
200.00		Subtotal (see instructions)		295,288,088	0	46,353	57,375,186	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		295,288,088	0	46,353	57,375,186	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/27/2020 12:39 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	3		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	743		54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	132		54.01
56.01	03480	ONCOLOGY	0	17,848		56.01
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
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	6		66.00
66.01	06601	IP REHAB THERAPIES	0	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	25		69.00
69.01	03630	CARDIAC CATH LAB	0	55		69.01
69.02	03160	CARDIAC REHABILITATION	0	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,386		73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	1,426		73.01
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						
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0		90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	0	21,631		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	21,631		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part II Date/Time Prepared: 2/27/2020 12:39 pm		
					Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)				
			1.00	2.00	3.00	4.00	5.00				
	ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	7,751,171	153,799,264	0.050398	0	0	50.00			
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,055,206	13,496,438	0.078184	0	0	52.00			
53.00	05300	ANESTHESIOLOGY	133,773	13,727,345	0.009745	0	0	53.00			
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,666,638	418,515,824	0.015929	135,204	2,154	54.00			
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	653,196	52,259,089	0.012499	0	0	54.01			
56.01	03480	ONCOLOGY	2,418,467	31,202,546	0.077509	0	0	56.01			
60.00	06000	LABORATORY	2,771,746	197,424,451	0.014040	308,028	4,325	60.00			
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	270,548	15,235,479	0.017758	1,173	21	62.00			
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30			
65.00	06500	RESPIRATORY THERAPY	557,282	29,823,177	0.018686	4,706	88	65.00			
66.00	06600	PHYSICAL THERAPY	1,942,785	44,903,118	0.043266	51,527	2,229	66.00			
66.01	06601	IP REHAB THERAPIES	256,775	11,269,892	0.022784	0	0	66.01			
69.00	06900	ELECTROCARDIOLOGY	1,608,282	55,979,759	0.028730	49,394	1,419	69.00			
69.01	03630	CARDIAC CATH LAB	1,172,779	63,939,652	0.018342	0	0	69.01			
69.02	03160	CARDIAC REHABILITATION	0	0	0.000000	0	0	69.02			
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,514,389	162,115,474	0.021678	16,845	365	71.00			
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,767,204	82,464,361	0.033556	0	0	72.00			
73.00	07300	DRUGS CHARGED TO PATIENTS	1,117,750	61,508,431	0.018172	238,229	4,329	73.00			
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	20,792	732,258	0.028394	0	0	73.01			
74.00	07400	RENAL DIALYSIS	207,043	6,355,406	0.032577	0	0	74.00			
76.97	07697	CARDIAC REHABILITATION	633,372	4,118,409	0.153790	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										
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,886,752	15,654,792	0.120522	307	37	90.01			
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	464,300	2,924,830	0.158744	44,625	7,084	90.02			
91.00	09100	EMERGENCY	2,515,622	140,654,928	0.017885	278,179	4,975	91.00			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,073,551	0.000000	224	0	92.00			
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	350,260	11,582,332	0.030241	14,599	441	92.01			
200.00		Total (lines 50 through 199)	40,736,132	1,591,760,806		1,143,040	27,467	200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	34,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	21,315	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	348,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	404,837	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	34,979	34,979	153,799,264	0.000227	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	21,315	21,315	13,496,438	0.001579	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,727,345	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	418,515,824	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	52,259,089	0.000000	54.01
56.01	03480	ONCOLOGY		0	0	0	31,202,546	0.000000	56.01
60.00	06000	LABORATORY		0	0	0	197,424,451	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	15,235,479	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	29,823,177	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	44,903,118	0.000000	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	11,269,892	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	55,979,759	0.000000	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	63,939,652	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	162,115,474	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	82,464,361	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	61,508,431	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	732,258	0.000000	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	6,355,406	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	4,118,409	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	15,654,792	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	2,924,830	0.000000	90.02
91.00	09100	EMERGENCY		0	348,543	348,543	140,654,928	0.002478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,073,551	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	11,582,332	0.000000	92.01
200.00		Total (lines 50 through 199)		0	404,837	404,837	1,591,760,806		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000227	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.001579	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	135,204	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	308,028	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	1,173	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	4,706	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	51,527	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	49,394	0	0	329	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	16,845	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	238,229	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	112	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	307	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	44,625	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.002478	278,179	689	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	224	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	14,599	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		1,143,040	689	441		0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-S252

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 12:39 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.245894	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.576295	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026602	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089717	0	0	256	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.071150	0	0	0	54.01
56.01	03480	ONCOLOGY	0.684217	0	0	0	56.01
60.00	06000	LABORATORY	0.134923	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.204164	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.153386	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.326021	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.375311	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.209890	329	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.082958	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.250538	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391029	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244392	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.393807	112	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.354998	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.643887	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.509823	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1.178830	0	0	0	90.02
91.00	09100	EMERGENCY	0.142444	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.690500	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.423844	0	0	0	92.01
200.00		Subtotal (see instructions)		441	0	256	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		441	0	256	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-S252

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 12:39 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	54.01
56.01	03480	ONCOLOGY	0	0	56.01
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	73.01
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					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
200.00		Subtotal (see instructions)	0	23	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	23	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-T252

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 12:39 pm

				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,751,171	153,799,264	0.050398	71,528	3,605	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,055,206	13,496,438	0.078184	0	0	52.00
53.00	05300	ANESTHESIOLOGY	133,773	13,727,345	0.009745	11,099	108	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,666,638	418,515,824	0.015929	645,348	10,280	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	653,196	52,259,089	0.012499	0	0	54.01
56.01	03480	ONCOLOGY	2,418,467	31,202,546	0.077509	5,032	390	56.01
60.00	06000	LABORATORY	2,771,746	197,424,451	0.014040	1,149,578	16,140	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	270,548	15,235,479	0.017758	55,093	978	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	557,282	29,823,177	0.018686	1,041,785	19,467	65.00
66.00	06600	PHYSICAL THERAPY	1,942,785	44,903,118	0.043266	8,412	364	66.00
66.01	06601	IP REHAB THERAPIES	256,775	11,269,892	0.022784	7,947,589	181,078	66.01
69.00	06900	ELECTROCARDIOLOGY	1,608,282	55,979,759	0.028730	47,724	1,371	69.00
69.01	03630	CARDIAC CATH LAB	1,172,779	63,939,652	0.018342	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,514,389	162,115,474	0.021678	288,147	6,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,767,204	82,464,361	0.033556	40,691	1,365	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,117,750	61,508,431	0.018172	1,091,189	19,829	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	20,792	732,258	0.028394	0	0	73.01
74.00	07400	RENAL DIALYSIS	207,043	6,355,406	0.032577	365,754	11,915	74.00
76.97	07697	CARDIAC REHABILITATION	633,372	4,118,409	0.153790	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,886,752	15,654,792	0.120522	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	464,300	2,924,830	0.158744	0	0	90.02
91.00	09100	EMERGENCY	2,515,622	140,654,928	0.017885	13,617	244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,073,551	0.000000	1,093	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	350,260	11,582,332	0.030241	12,014	363	92.01
200.00		Total (lines 50 through 199)	40,736,132	1,591,760,806		12,795,693	273,743	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	34,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	21,315	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	348,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	404,837	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	34,979	34,979	153,799,264	0.000227	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	21,315	21,315	13,496,438	0.001579	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,727,345	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	418,515,824	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	52,259,089	0.000000	54.01
56.01	03480	ONCOLOGY		0	0	0	31,202,546	0.000000	56.01
60.00	06000	LABORATORY		0	0	0	197,424,451	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	15,235,479	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	29,823,177	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	44,903,118	0.000000	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	11,269,892	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	55,979,759	0.000000	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	63,939,652	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	162,115,474	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	82,464,361	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	61,508,431	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	732,258	0.000000	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	6,355,406	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	4,118,409	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	15,654,792	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	2,924,830	0.000000	90.02
91.00	09100	EMERGENCY		0	348,543	348,543	140,654,928	0.002478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,073,551	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	11,582,332	0.000000	92.01
200.00		Total (lines 50 through 199)		0	404,837	404,837	1,591,760,806		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000227		71,528		16	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.001579		0		0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		11,099		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		645,348		0	3,504	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000		0		0	0	54.01
56.01	03480	ONCOLOGY	0.000000		5,032		0	0	56.01
60.00	06000	LABORATORY	0.000000		1,149,578		0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		55,093		0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		0		0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		1,041,785		0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		8,412		0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000		7,947,589		0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		47,724		0	693	69.00
69.01	03630	CARDIAC CATH LAB	0.000000		0		0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000		0		0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		288,147		0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		40,691		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		1,091,189		0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000		0		0	392	73.01
74.00	07400	RENAL DIALYSIS	0.000000		365,754		0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0		0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0		0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000		0		0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000		0		0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000		0		0	0	90.02
91.00	09100	EMERGENCY	0.002478		13,617		34	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		1,093		0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		12,014		0	0	92.01
200.00		Total (lines 50 through 199)			12,795,693		50	4,589	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-T252

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 12:39 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.245894	0	0	98	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.576295	0	0	0	0
53.00	05300 ANESTHESIOLOGY	0.026602	0	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.089717	3,504	0	564	314
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.071150	0	0	0	0
56.01	03480 ONCOLOGY	0.684217	0	0	0	0
60.00	06000 LABORATORY	0.134923	0	0	0	0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.204164	0	0	0	0
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.153386	0	0	0	0
66.00	06600 PHYSICAL THERAPY	0.326021	0	0	0	0
66.01	06601 IP REHAB THERAPIES	0.375311	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.209890	693	0	31	145
69.01	03630 CARDIAC CATH LAB	0.082958	0	0	0	0
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.250538	0	0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.391029	0	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.244392	0	0	0	0
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.393807	392	0	0	154
74.00	07400 RENAL DIALYSIS	0.354998	0	0	0	0
76.97	07697 CARDIAC REHABILITATION	0.643887	0	0	0	0
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.509823	0	0	0	0
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	1.178830	0	0	0	0
91.00	09100 EMERGENCY	0.142444	0	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.690500	0	0	0	0
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.423844	0	0	0	0
200.00	Subtotal (see instructions)		4,589	0	693	613
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00	Net Charges (line 200 - line 201)		4,589	0	693	613

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-T252

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 12:39 pm

Title XVIII

Subprovider -
IRF

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	24	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	54.01
56.01	03480	ONCOLOGY	0	0	56.01
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	7	69.00
69.01	03630	CARDIAC CATH LAB	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	73.01
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				
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
200.00		Subtotal (see instructions)	0	82	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	82	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/27/2020 12:39 pm

			Title XIX		Hospital	Cost	
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	10,174,240	0	10,174,240	72,224	140.87	30.00
31.00	INTENSIVE CARE UNIT	2,704,000		2,704,000	7,206	375.24	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	406,351		406,351	3,608	112.63	35.00
40.00	SUBPROVIDER - IPF	2,039,470	0	2,039,470	14,415	141.48	40.00
41.00	SUBPROVIDER - IRF	1,153,610	0	1,153,610	8,515	135.48	41.00
43.00	NURSERY	473,561		473,561	4,918	96.29	43.00
200.00	Total (lines 30 through 199)	16,951,232		16,951,232	110,886		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,951	415,707				30.00
31.00	INTENSIVE CARE UNIT	242	90,808				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	311	35,028				35.00
40.00	SUBPROVIDER - IPF	1,788	252,966				40.00
41.00	SUBPROVIDER - IRF	131	17,748				41.00
43.00	NURSERY	932	89,742				43.00
200.00	Total (lines 30 through 199)	6,355	901,999				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description		Title XIX		Hospital		Cost	
		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	7,751,171	0	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,055,206	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	133,773	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,666,638	0	0.000000	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	653,196	0	0.000000	0	54.01
56.01	03480	ONCOLOGY	2,418,467	0	0.000000	0	56.01
60.00	06000	LABORATORY	2,771,746	0	0.000000	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	270,548	0	0.000000	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	557,282	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	1,942,785	0	0.000000	0	66.00
66.01	06601	IP REHAB THERAPIES	256,775	0	0.000000	0	66.01
69.00	06900	ELECTROCARDIOLOGY	1,608,282	0	0.000000	0	69.00
69.01	03630	CARDIAC CATH LAB	1,172,779	0	0.000000	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0.000000	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,514,389	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,767,204	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,117,750	0	0.000000	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	20,792	0	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	207,043	0	0.000000	0	74.00
76.97	07697	CARDIAC REHABILITATION	633,372	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,886,752	0	0.000000	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	464,300	0	0.000000	0	90.02
91.00	09100	EMERGENCY	2,515,622	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	201,584	0	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	350,260	0	0.000000	0	92.01
200.00		Total (lines 50 through 199)	40,937,716	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/27/2020 12:39 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	48,643	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	0	17,490	0	31.00			
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	17,490	0	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00			
43.00	04300	NURSERY	0	0	0	0	0	43.00			
200.00		Total (lines 30 through 199)	0	0	0	83,623	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	48,643	72,224	0.67	2,951	30.00			
31.00	03100	INTENSIVE CARE UNIT		17,490	7,206	2.43	242	31.00			
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	3,608	0.00	311	35.00			
40.00	04000	SUBPROVIDER - IPF	0	17,490	14,415	1.21	1,788	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	8,515	0.00	131	41.00			
43.00	04300	NURSERY		0	4,918	0.00	932	43.00			
200.00		Total (lines 30 through 199)		83,623	110,886		6,355	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	1,977								30.00
31.00	03100	INTENSIVE CARE UNIT	588								31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0								35.00
40.00	04000	SUBPROVIDER - IPF	2,163								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	4,728								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Hospital		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	34,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	21,315	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	348,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	404,837	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 12:39 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)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	34,979	34,979	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,315	21,315	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	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							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	348,543	348,543	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	404,837	404,837	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 12:39 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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	34,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	21,315	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	348,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	404,837	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Subprovider - IPF		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)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	34,979	34,979	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	21,315	21,315	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0.000000	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY		0	0	0	0	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0.000000	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY		0	348,543	348,543	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)		0	404,837	404,837	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0.000000	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0.000000	0	0	0	0	56.01
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES		0.000000	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0.000000	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS		0.000000	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0.000000	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	34,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	21,315	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
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
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	348,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	404,837	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
			Title XIX		Subprovider - IRF		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)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	34,979	34,979	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,315	21,315	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	348,543	348,543	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	404,837	404,837	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 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)			72,224	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			72,224	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)			70,793	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)			32,763	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)			72,264,079	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)			72,264,079	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)			72,264,079	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,000.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			32,781,020	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)			32,781,020	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 12:39 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)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	19,471,483	7,206	2,702.12	4,145	11,200,287		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	NEONATAL INTENSIVE CARE UNIT	3,521,722	3,608	976.09	0	0		47.00
Cost Center Description							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					54,106,791		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					98,088,098		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)					6,202,717		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,437,238		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					12,639,955		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					85,448,143		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)					1,431		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,000.55		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,431,787		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 12:39 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	10,174,240	72,264,079	0.140792	1,431,787	201,584	90.00
91.00 Nursing School cost	0	72,264,079	0.000000	1,431,787	0	91.00
92.00 Allied health cost	48,643	72,264,079	0.000673	1,431,787	964	92.00
93.00 All other Medical Education	0	72,264,079	0.000000	1,431,787	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,415	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,415	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)		14,415	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,874	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)		15,838,984	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)		15,838,984	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)		15,838,984	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,098.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,157,894	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,157,894	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					243,363	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,401,257	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)					410,092	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					28,156	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					438,248	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,963,009	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,039,470	15,838,984	0.128763	0	0	90.00
91.00	Nursing School cost	0	15,838,984	0.000000	0	0	91.00
92.00	Allied health cost	17,490	15,838,984	0.001104	0	0	92.00
93.00	All other Medical Education	0	15,838,984	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,515	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,515	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)		8,515	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)		6,058	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,976,695	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,976,695	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,976,695	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)		819.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,963,562	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,963,562	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm
			Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,893,856
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,857,418
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					820,738
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					273,793
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,094,531
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,762,887
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,153,610	6,976,695	0.165352	0	0	90.00
91.00	Nursing School cost	0	6,976,695	0.000000	0	0	91.00
92.00	Allied health cost	0	6,976,695	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,976,695	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 12:39 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)	72,224	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	72,224	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)	70,793	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,951	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)	4,918	15.00
16.00	Nursery days (title V or XIX only)	932	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)	72,264,079	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)	72,264,079	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)	72,264,079	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,000.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,952,623	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,952,623	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 12:39 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)	4,234,105	4,918	860.94	932	802,396	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	19,358,393	7,206	2,686.43	242	650,116	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	NEONATAL INTENSIVE CARE UNIT	3,521,722	3,608	976.09	311	303,564	47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,708,699	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)					1,431	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,000.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,431,787	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XIX		Hospital		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	10,174,240	72,264,079	0.140792	1,431,787	201,584
91.00	Nursing School cost	0	72,264,079	0.000000	1,431,787	0
92.00	Allied health cost	48,643	72,264,079	0.000673	1,431,787	964
93.00	All other Medical Education	0	72,264,079	0.000000	1,431,787	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm
		Title XIX	Subprovider - IPF	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)			14,415 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,415 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)			14,415 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)			1,788 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)			4,918 15.00
16.00	Nursery days (title V or XIX only)			932 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)			15,838,984 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)			15,838,984 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)			15,838,984 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,098.78 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,964,619 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)			1,964,619 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Subprovider - IPF	Cost
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,964,619	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)					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: 14-0252 Component CCN: 14-S252		Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XIX		Subprovider - IPF	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	2,039,470	15,838,984	0.128763	0	0	90.00
91.00 Nursing School cost	0	15,838,984	0.000000	0	0	91.00
92.00 Allied health cost	17,490	15,838,984	0.001104	0	0	92.00
93.00 All other Medical Education	0	15,838,984	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm
		Title XIX	Subprovider - IRF	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)		8,515	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,515	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)		8,515	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)		131	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)		4,918	15.00
16.00	Nursery days (title V or XIX only)		932	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,976,695	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,976,695	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,976,695	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)		819.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		107,334	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)		107,334	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Subprovider - IRF	Cost
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					107,334	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)					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: 14-0252 Component CCN: 14-T252		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/27/2020 12:39 pm	
				Title XIX		Subprovider - IRF		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			1,153,610	6,976,695	0.165352	0	0	90.00
91.00	Nursing School cost			0	6,976,695	0.000000	0	0	91.00
92.00	Allied health cost			0	6,976,695	0.000000	0	0	92.00
93.00	All other Medical Education			0	6,976,695	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 12:39 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		63,452,249		30.00
31.00	03100	INTENSIVE CARE UNIT		19,048,107		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.245894	24,412,125	6,002,795	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.576295	3,847	2,217	52.00
53.00	05300	ANESTHESIOLOGY	0.026602	3,042,017	80,924	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089717	50,336,898	4,516,075	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.071150	200,141	14,240	54.01
56.01	03480	ONCOLOGY	0.685209	188,422	129,108	56.01
60.00	06000	LABORATORY	0.135340	37,816,238	5,118,050	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.204164	5,000,193	1,022,084	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.153386	14,295,645	2,192,752	65.00
66.00	06600	PHYSICAL THERAPY	0.326021	4,945,344	1,612,286	66.00
66.01	06601	IP REHAB THERAPIES	0.375311	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.209890	7,165,883	1,504,047	69.00
69.01	03630	CARDIAC CATH LAB	0.082958	14,538,350	1,206,072	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.250538	38,659,243	9,685,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391029	26,243,718	10,262,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244392	22,785,548	5,568,606	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.393807	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.354998	2,989,990	1,061,440	74.00
76.97	07697	CARDIAC REHABILITATION	0.643887	3,443	2,217	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						
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.509823	37,213	18,972	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1.178830	10,200	12,024	90.02
91.00	09100	EMERGENCY	0.143330	23,880,152	3,422,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.690500	165,049	113,966	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.423844	1,317,726	558,510	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		278,043,385	54,106,791	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)		278,043,385		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		6,850,194		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.245894	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.576295	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.026602	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.089717	135,204	12,130	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.071150	0	0	54.01
56.01	03480 ONCOLOGY	0.685209	0	0	56.01
60.00	06000 LABORATORY	0.135340	308,028	41,689	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.204164	1,173	239	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.153386	4,706	722	65.00
66.00	06600 PHYSICAL THERAPY	0.326021	51,527	16,799	66.00
66.01	06601 IP REHAB THERAPIES	0.375311	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.209890	49,394	10,367	69.00
69.01	03630 CARDIAC CATH LAB	0.082958	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.250538	16,845	4,220	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.391029	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.244392	238,229	58,221	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.393807	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.354998	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.643887	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					
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.509823	307	157	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	1.178830	44,625	52,605	90.02
91.00	09100 EMERGENCY	0.143330	278,179	39,871	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.690500	224	155	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.423844	14,599	6,188	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,143,040	243,363	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)		1,143,040		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		10,601,335		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.245894	71,528	17,588	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.576295		0	52.00
53.00	05300 ANESTHESIOLOGY	0.026602	11,099	295	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.089717	645,348	57,899	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.071150		0	54.01
56.01	03480 ONCOLOGY	0.685209	5,032	3,448	56.01
60.00	06000 LABORATORY	0.135340	1,149,578	155,584	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.204164	55,093	11,248	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.153386	1,041,785	159,795	65.00
66.00	06600 PHYSICAL THERAPY	0.326021	8,412	2,742	66.00
66.01	06601 IP REHAB THERAPIES	0.375311	7,947,589	2,982,818	66.01
69.00	06900 ELECTROCARDIOLOGY	0.209890	47,724	10,017	69.00
69.01	03630 CARDIAC CATH LAB	0.082958	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.250538	288,147	72,192	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.391029	40,691	15,911	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.244392	1,091,189	266,678	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.393807	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.354998	365,754	129,842	74.00
76.97	07697 CARDIAC REHABILITATION	0.643887	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					
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.509823	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	1.178830	0	0	90.02
91.00	09100 EMERGENCY	0.143330	13,617	1,952	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.690500	1,093	755	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.423844	12,014	5,092	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		12,795,693	3,893,856	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)		12,795,693		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 12:39 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	56.01
60.00	06000	LABORATORY	0.000000	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	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						
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XIX	Subprovider - IPF	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		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	54.01
56.01	03480 ONCOLOGY	0.000000	0	0	56.01
60.00	06000 LABORATORY	0.000000	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	66.00
66.01	06601 IP REHAB THERAPIES	0.000000	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03630 CARDIAC CATH LAB	0.000000	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	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					
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.000000	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A
Date/Time Prepared:
2/27/2020 12:39 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)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			80,400,988	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			1,036,771	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			413.66	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			2.32	30.00
31.00	Percentage of Medicaid patient days (see instructions)			13.28	31.00
32.00	Sum of lines 30 and 31			15.60	32.00
33.00	Allowable disproportionate share percentage (see instructions)			2.89	33.00
34.00	Disproportionate share adjustment (see instructions)			580,897	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/27/2020 12:39 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	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000407375		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	3,370,161	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	3,370,161	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,370,161		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	85,388,817			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			85,388,817	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			7,065,216	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			100,636	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			32,023	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			64,800	58.00
59.00	Total (sum of amounts on lines 49 through 58)			92,651,492	59.00
60.00	Primary payer payments			39,240	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			92,612,252	61.00
62.00	Deductibles billed to program beneficiaries			8,340,368	62.00
63.00	Coinsurance billed to program beneficiaries			172,118	63.00
64.00	Allowable bad debts (see instructions)			1,658,237	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			1,077,854	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			645,044	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			85,177,620	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJ-ALLIED HEALTH A&G			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-127,299	70.93
70.94	HRR adjustment amount (see instructions)			-249,243	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/27/2020 12:39 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)		84,801,078	71.00	
71.01	Sequestration adjustment (see instructions)		1,696,022	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		82,934,880	72.00	
73.00	Tentative settlement (for contractor use only)		0	73.00	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		170,176	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,585,989	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/27/2020 12:39 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
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	80,400,988	0	0	80,400,988	80,400,988
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	1,036,771	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,036,771	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
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	0.000000
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0289	0.0289	0.0289	0.0289	0.0289
11.00	Disproportionate share adjustment (see instructions)	34.00	580,897	0	0	580,897	580,897
11.01	Uncompensated care payments	36.00	3,370,161	0	0	1,639,612	1,639,612
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	85,388,817	0	1,036,771	84,352,046	85,388,817
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	85,388,817	0	1,036,771	84,352,046	85,388,817
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	7,065,216	0	0	7,065,216	7,065,216

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/27/2020 12:39 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	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,036,771	91,417,262	92,454,033	19.00
		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	6,540,982	0	0	6,540,982	6,540,982	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	314,268	0	0	314,268	314,268	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0321	0.0321	0.0321	0.0321		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	209,966	0	0	209,966	209,966	25.00
26.00	Total prospective capital payments (see instructions)	12.00	7,065,216	0	0	7,065,216	7,065,216	26.00
		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		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2020 12:39 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	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	80,400,988		80,400,988	80,400,988	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	1,036,771		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,036,771		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	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	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0289	0.0289	0.0289		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	580,897	0	580,897	580,897	11.00
11.01	Uncompensated care payments	36.00	3,370,161	0	3,370,161	3,370,161	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	85,388,817	1,036,771	84,352,046	85,388,817	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	85,388,817	1,036,771	84,352,046	85,388,817	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	7,065,216	0	7,065,216	7,065,216	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			1,036,771	91,417,262	92,454,033	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2020 12:39 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	6,540,982	0	6,540,982	6,540,982	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	314,268	0	314,268	314,268	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	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0321	0.0321	0.0321		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	209,966	0	209,966	209,966	25.00
26.00	Total prospective capital payments (see instructions)	12.00	7,065,216	0	7,065,216	7,065,216	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	-127,299	0	-127,299	-127,299	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	-249,243	0	-249,243	-249,243	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.		Y				100.00

Health Financial Systems		NORTHWEST COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		21,631	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		57,317,641	2.00	
3.00	OPPS payments		53,087,054	3.00	
4.00	Outlier payment (see instructions)		17,978	4.00	
4.01	Outlier reconciliation amount (see instructions)		0	4.01	
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.899	5.00	
6.00	Line 2 times line 5		51,528,559	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		57,545	9.00	
10.00	Organ acquisitions		0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)		21,631	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		46,353	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)		46,353	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)		46,353	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		24,722	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)		21,631	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)		53,162,577	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)		9,936,384	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)		43,247,824	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)		43,247,824	30.00	
31.00	Primary payer payments		4,801	31.00	
32.00	Subtotal (line 30 minus line 31)		43,243,023	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)		1,441,446	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		936,940	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		681,540	36.00	
37.00	Subtotal (see instructions)		44,179,963	37.00	
38.00	MSP-LCC reconciliation amount from PS&R		142	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)		44,179,821	40.00	
40.01	Sequestration adjustment (see instructions)		883,596	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
41.00	Interim payments		43,059,510	41.00	
42.00	Tentative settlement (for contractors use only)		0	42.00	
43.00	Balance due provider/program (see instructions)		236,715	43.00	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00	
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)		0	90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00	
92.00	The rate used to calculate the Time Value of Money		0.00	92.00	
93.00	Time Value of Money (see instructions)		0	93.00	
94.00	Total (sum of lines 91 and 93)		0	94.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 12:39 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		23	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		113	2.00
3.00	OPPS payments		134	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		23	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		256	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)		256	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)		256	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		233	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)		23	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)		134	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)		11	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)		146	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)		146	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		146	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)		146	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		146	40.00
40.01	Sequestration adjustment (see instructions)		3	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		170	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-27	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 12:39 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		82	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		613	2.00
3.00	OPPS payments		740	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		82	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		693	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)		693	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)		693	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		611	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)		82	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)		740	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)		95	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)		727	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)		727	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		727	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)		727	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		727	40.00
40.01	Sequestration adjustment (see instructions)		15	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		769	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-57	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/27/2020 12:39 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		82,172,055		42,310,260	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		671,925		647,950	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) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER	04/17/2019	90,900	04/17/2019	101,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		90,900		101,300	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)		82,934,880		43,059,510	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) Program to Provider					5.00
Provider to Program						
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		170,176		236,715	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		83,105,056		43,296,225	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: 14-0252

Period:

Worksheet E-1

Component CCN: 14-S252

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:39 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,396,780		170	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,396,780		170	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		137,518		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		27	6.02
7.00	Total Medicare program liability (see instructions)		2,534,298		143	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: 14-0252

Period:

Worksheet E-1

Component CCN: 14-T252

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:39 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		9,787,421		769	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,787,421		769	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		101,233		57	6.02
7.00	Total Medicare program liability (see instructions)		9,686,188		712	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part II
Date/Time Prepared:
2/27/2020 12:39 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: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part II Date/Time Prepared: 2/27/2020 12:39 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,740,385 1.00
2.00	Net IPF PPS Outlier Payments			3,349 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			39.493151 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,743,734 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,743,734 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,743,734 18.00
19.00	Deductibles			207,708 19.00
20.00	Subtotal (line 18 minus line 19)			2,536,026 20.00
21.00	Coinsurance			90,332 21.00
22.00	Subtotal (line 20 minus line 21)			2,445,694 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			209,473 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			136,157 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			51,779 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,581,851 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			4,167 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,586,018 31.00
31.01	Sequestration adjustment (see instructions)			51,720 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,396,780 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			137,518 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			3,349 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part III Date/Time Prepared: 2/27/2020 12:39 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)		9,504,301	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0186	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		166,325	3.00
4.00	Outlier Payments		307,890	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		23.328767	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		9,978,516	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		9,978,516	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		9,978,516	19.00
20.00	Deductibles		32,520	20.00
21.00	Subtotal (line 19 minus line 20)		9,945,996	21.00
22.00	Coinsurance		63,198	22.00
23.00	Subtotal (line 21 minus line 22)		9,882,798	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,564	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		1,017	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,340	26.00
27.00	Subtotal (sum of lines 23 and 25)		9,883,815	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		50	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		9,883,865	32.00
32.01	Sequestration adjustment (see instructions)		197,677	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		9,787,421	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		-101,233	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		7,953	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		307,890	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2020 12:39 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	4,708,699			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)	4,708,699		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)	4,708,699		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)	4,708,699		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			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)	0		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	4,708,699		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			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)	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			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			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: 14-0252 Component CCN: 14-S252	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XIX	Subprovider - IPF	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		1,964,619		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)		1,964,619	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)		1,964,619	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)		1,964,619	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		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	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)		1,964,619	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		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		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		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2020 12:39 pm	
		Title XIX	Subprovider - IRF	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		107,334		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)		107,334	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)		107,334	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)		107,334	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		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	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)		107,334	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		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		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		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

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

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/27/2020 12:39 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	3,620,875	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	52,093,793	0	0	0	4.00
5.00 Other receivable	36,241,543	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	9,163,194	0	0	0	7.00
8.00 Prepaid expenses	3,955,420	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	105,074,825	0	0	0	11.00
FIXED ASSETS					
12.00 Land	89,072	0	0	0	12.00
13.00 Land improvements	15,182,111	0	0	0	13.00
14.00 Accumulated depreciation	-12,243,791	0	0	0	14.00
15.00 Buildings	318,705,276	0	0	0	15.00
16.00 Accumulated depreciation	-158,720,419	0	0	0	16.00
17.00 Leasehold improvements	3,480,507	0	0	0	17.00
18.00 Accumulated depreciation	-2,409,691	0	0	0	18.00
19.00 Fixed equipment	216,463,568	0	0	0	19.00
20.00 Accumulated depreciation	-131,514,893	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	253,345,646	0	0	0	23.00
24.00 Accumulated depreciation	-148,088,836	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)	354,288,550	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	49,783,210	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	49,783,210	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	509,146,585	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	14,756,294	0	0	0	37.00
38.00 Salaries, wages, and fees payable	44,382,714	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	7,925,000	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	45,938,281	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	113,002,289	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	235,036,629	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	32,708,250	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	267,744,879	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	380,747,168	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	128,399,417				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)	128,399,417	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	509,146,585	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/27/2020 12:39 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		135,417,643		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		28,737,913				2.00
3.00	Total (sum of line 1 and line 2)		164,155,556		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED NET ASSETS TRANSFER	1,000,000		0		0	5.00
6.00	NET ASSETS IN FOUNDATION	5,851,539		0		0	6.00
7.00	RECONCILING ITEM	2		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)		6,851,541		0		10.00
11.00	Subtotal (line 3 plus line 10)		171,007,097		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS TO AFFILIATES	37,000,000		0		0	13.00
14.00	PENSION RELATED CHANGES	5,051,148		0		0	14.00
15.00	RESTRICTED NET ASSETS TRANSFER	556,532		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)		42,607,680		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		128,399,417		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	RESTRICTED NET ASSETS TRANSFER		0				5.00
6.00	NET ASSETS IN FOUNDATION		0				6.00
7.00	RECONCILING ITEM		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	TRANSFERS TO AFFILIATES		0				13.00
14.00	PENSION RELATED CHANGES		0				14.00
15.00	RESTRICTED NET ASSETS TRANSFER		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: 14-0252

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2020 12:39 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	154,743,601		154,743,601	1.00
2.00	SUBPROVIDER - IPF	34,368,066		34,368,066	2.00
3.00	SUBPROVIDER - IRF	26,169,598		26,169,598	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	215,281,265		215,281,265	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	39,815,797		39,815,797	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	11,445,135		11,445,135	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	51,260,932		51,260,932	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	266,542,197		266,542,197	17.00
18.00	Ancillary services	584,344,736	982,902,140	1,567,246,876	18.00
19.00	Outpatient services	0	0	0	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		11,588,453	11,588,453	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	RESIDENTIAL TREATMENT CENTER	2,084,656	226,363	2,311,019	27.00
27.01	OTHER NRCC CHARGES	3,915,740	851,457	4,767,197	27.01
27.02	MOBILE DENTAL CLINIC	0	888,188	888,188	27.02
27.03	CORPORATE HEALTH	0	-20,712	-20,712	27.03
27.04	OTHER (SPECIFY)	0	0	0	27.04
27.05	OTHER (SPECIFY)	0	0	0	27.05
27.06	RECONCILING ITEM	0	3	3	27.06
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	856,887,329	996,435,892	1,853,323,221	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		488,894,783		29.00
30.00	GOODWILL AMORTIZATION YE AJE	879,001			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00	OTHER	0			35.00
36.00	Total additions (sum of lines 30-35)		879,001		36.00
37.00	PROVISION FOR BA DEBT - MISC RECEIP	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		489,773,784		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/27/2020 12:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,853,323,221	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,345,829,507	2.00
3.00	Net patient revenues (line 1 minus line 2)	507,493,714	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	489,773,784	4.00
5.00	Net income from service to patients (line 3 minus line 4)	17,719,930	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,527,096	6.00
7.00	Income from investments	20	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	26,361	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	1,881,990	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHYSICIANS OFFICES	637,401	24.00
24.01	OTHER REVENUE	4,591,039	24.01
24.02	MGT SERVICES	960,263	24.02
24.03	OTHER MISC	136,721	24.03
24.04	OP PHARMACY	3,665,828	24.04
24.05	RESEARCH	14,750	24.05
24.06	LOSS ON SALE OF INVESTMENT	-448,728	24.06
24.07	NON OPERATING REVENUE	-3,178,629	24.07
24.08	INTERCOMPANY RENTAL	1,203,873	24.08
24.09	OTHER (SPECIFY)	0	24.09
25.00	Total other income (sum of lines 6-24)	11,017,985	25.00
26.00	Total (line 5 plus line 25)	28,737,915	26.00
27.00	RECONCILING ITEM	2	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	28,737,913	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN: 14-0252 HHA CCN: 14-7094	Period: From 10/01/2018 To 09/30/2019	Worksheet H Date/Time Prepared: 2/27/2020 12:39 pm
						Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Pur- chased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	964	964	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	1,229,713	89,794	0	1,134,000	389,807	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	2,168,732	158,362	69,921	0	2,397,015	6.00
7.00	Physical Therapy	1,943,975	141,950	61,791	0	2,147,716	7.00
8.00	Occupational Therapy	480,890	35,115	15,319	0	531,324	8.00
9.00	Speech Pathology	61,323	4,478	2,210	0	68,011	9.00
10.00	Medical Social Services	78,025	5,697	592	0	84,314	10.00
11.00	Home Health Aide	66,634	4,866	3,710	0	75,210	11.00
12.00	Supplies (see instructions)	0	0	0	0	278,144	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	6,029,292	440,262	153,543	1,134,000	668,915	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	964	0	964		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	2,843,314	593	2,843,907		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	2,397,015	0	2,397,015		6.00
7.00	Physical Therapy	0	2,147,716	0	2,147,716		7.00
8.00	Occupational Therapy	0	531,324	0	531,324		8.00
9.00	Speech Pathology	0	68,011	0	68,011		9.00
10.00	Medical Social Services	0	84,314	0	84,314		10.00
11.00	Home Health Aide	0	75,210	0	75,210		11.00
12.00	Supplies (see instructions)	0	278,144	0	278,144		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	0	8,426,012	593	8,426,605		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0252

Period:

Worksheet H-1

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:39 pmHome Health
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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
			Bldgs & Fixtures	Movable Equipment					
		0	1.00	2.00	3.00	4.00	4A.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	964	0	0	964		0	3.00	
4.00	Transportation	0	0	0	0	0		4.00	
5.00	Administrative and General	2,843,907	0	0	964	0	2,844,871	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	2,397,015	0	0	0	0	2,397,015	6.00	
7.00	Physical Therapy	2,147,716	0	0	0	0	2,147,716	7.00	
8.00	Occupational Therapy	531,324	0	0	0	0	531,324	8.00	
9.00	Speech Pathology	68,011	0	0	0	0	68,011	9.00	
10.00	Medical Social Services	84,314	0	0	0	0	84,314	10.00	
11.00	Home Health Aide	75,210	0	0	0	0	75,210	11.00	
12.00	Supplies (see instructions)	278,144	0	0	0	0	278,144	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	8,426,605	0	0	964	0	8,426,605	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
		GENERAL SERVICE COST CENTERS							
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	2,844,871						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,362,282	3,759,297					6.00	
7.00	Physical Therapy	1,026,823	3,174,539					7.00	
8.00	Occupational Therapy	135,731	667,055					8.00	
9.00	Speech Pathology	18,578	86,589					9.00	
10.00	Medical Social Services	97,127	181,441					10.00	
11.00	Home Health Aide	48,968	124,178					11.00	
12.00	Supplies (see instructions)	46,226	324,370					12.00	
13.00	Drugs	0	0					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	109,136	109,136					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		8,426,605					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0252

Period:

Worksheet H-1

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 12:39 pmHome Health
Agency I

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	100	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	100	0	-2,844,871	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	6,470,513	6.00
7.00	Physical Therapy	0	0	0	0	4,536,155	7.00
8.00	Occupational Therapy	0	0	0	0	352,184	8.00
9.00	Speech Pathology	0	0	0	0	52,917	9.00
10.00	Medical Social Services	0	0	0	0	547,912	10.00
11.00	Home Health Aide	0	0	0	0	243,535	11.00
12.00	Supplies (see instructions)	0	0	0	0	22,755	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	710,394	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	100	0	10,091,494	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	964	0	2,844,871	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	9.640000	0.000000	0.153627	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0252

Period:

Worksheet H-2

HHA CCN: 14-7094

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

2/27/2020 12:39 pm

Home Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	206,142	21,559	192,673	420,374	184,031	1.00
2.00	Skilled Nursing Care	3,759,297	0	0	339,649	4,098,946	1,148,993	2.00
3.00	Physical Therapy	3,174,539	0	0	304,450	3,478,989	929,814	3.00
4.00	Occupational Therapy	667,055	0	0	75,313	742,368	144,465	4.00
5.00	Speech Pathology	86,589	0	0	9,604	96,193	16,220	5.00
6.00	Medical Social Services	181,441	0	0	12,220	193,661	62,819	6.00
7.00	Home Health Aide	124,178	0	0	10,436	134,614	54,640	7.00
8.00	Supplies (see instructions)	324,370	0	0	0	324,370	87,701	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	109,136	0	0	0	109,136	24,874	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	8,426,605	206,142	21,559	944,345	9,598,651	2,653,557	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	319,725	0	121,194	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	319,725	0	121,194	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0252

Period:

Worksheet H-2

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:39 pmHome Health
Agency I

PPS

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
		19.00	20.00	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	23.00	24.00	
1.00	Administrative and General	0	0	0	0	0	1,045,324	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	5,247,939	2.00
3.00	Physical Therapy	0	0	0	0	0	4,408,803	3.00
4.00	Occupational Therapy	0	0	0	0	0	886,833	4.00
5.00	Speech Pathology	0	0	0	0	0	112,413	5.00
6.00	Medical Social Services	0	0	0	0	0	256,480	6.00
7.00	Home Health Aide	0	0	0	0	0	189,254	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	412,071	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	134,010	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	12,693,127	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0252

Period:

Worksheet H-2

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:39 pmHome Health
Agency I

PPS

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General	0	1,045,324				1.00
2.00	Skilled Nursing Care	0	5,247,939	470,974	5,718,913		2.00
3.00	Physical Therapy	0	4,408,803	395,664	4,804,467		3.00
4.00	Occupational Therapy	0	886,833	79,588	966,421		4.00
5.00	Speech Pathology	0	112,413	10,088	122,501		5.00
6.00	Medical Social Services	0	256,480	23,018	279,498		6.00
7.00	Home Health Aide	0	189,254	16,984	206,238		7.00
8.00	Supplies (see instructions)	0	412,071	36,981	449,052		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	134,010	12,027	146,037		19.00
19.50	Telemedicine	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	0	12,693,127	1,045,324	12,693,127		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.089744			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0252
HHA CCN: 14-7094Period:
From 10/01/2018
To 09/30/2019Worksheet H-2
Part II
Date/Time Prepared:
2/27/2020 12:39 pm

						Home Health Agency I	2/27/2020 12:39 pm PPS	
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	5,176	21,492	1,230,258	53,995	474,369	0	1.00
2.00	Skilled Nursing Care	0	0	2,168,732	-1,137,234	2,961,712	0	2.00
3.00	Physical Therapy	0	0	1,943,975	-1,082,239	2,396,750	0	3.00
4.00	Occupational Therapy	0	0	480,890	-369,985	372,383	0	4.00
5.00	Speech Pathology	0	0	61,323	-54,384	41,809	0	5.00
6.00	Medical Social Services	0	0	78,026	-31,734	161,927	0	6.00
7.00	Home Health Aide	0	0	66,634	6,229	140,843	0	7.00
8.00	Supplies (see instructions)	0	0	0	-98,305	226,065	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	-45,020	64,116	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	5,176	21,492	6,029,838		6,839,974	0	20.00
21.00	Total cost to be allocated	206,142	21,559	944,345		2,653,557	0	21.00
22.00	Unit cost multiplier	39.826507	1.003117	0.156612		0.387948	0.000000	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	5,176	0	5,176	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	5,176	0	5,176	0	0	0	20.00
21.00	Total cost to be allocated	319,725	0	121,194	0	0	0	21.00
22.00	Unit cost multiplier	61.770672	0.000000	23.414606	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0252

Period:

Worksheet H-2

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 12:39 pm

				Home Health Agency I		PPS	
Cost Center Description		NURSING ADMINISTRATION (FTE'S NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)
		13.00	14.00	15.00	16.00	17.00	19.00
1.00	Administrative and General	0	0	0	0	0	0
2.00	Skilled Nursing Care	0	0	0	0	0	0
3.00	Physical Therapy	0	0	0	0	0	0
4.00	Occupational Therapy	0	0	0	0	0	0
5.00	Speech Pathology	0	0	0	0	0	0
6.00	Medical Social Services	0	0	0	0	0	0
7.00	Home Health Aide	0	0	0	0	0	0
8.00	Supplies (see instructions)	0	0	0	0	0	0
9.00	Drugs	0	0	0	0	0	0
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	0	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0
21.00	Total cost to be allocated	0	0	0	0	0	0
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000
Cost Center Description		NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED PRGM (ASSIGNED TIME)		
		20.00	21.00	22.00	23.00		
1.00	Administrative and General	0	0	0	0		
2.00	Skilled Nursing Care	0	0	0	0		
3.00	Physical Therapy	0	0	0	0		
4.00	Occupational Therapy	0	0	0	0		
5.00	Speech Pathology	0	0	0	0		
6.00	Medical Social Services	0	0	0	0		
7.00	Home Health Aide	0	0	0	0		
8.00	Supplies (see instructions)	0	0	0	0		
9.00	Drugs	0	0	0	0		
10.00	DME	0	0	0	0		
11.00	Home Dialysis Aide Services	0	0	0	0		
12.00	Respiratory Therapy	0	0	0	0		
13.00	Private Duty Nursing	0	0	0	0		
14.00	Clinic	0	0	0	0		
15.00	Health Promotion Activities	0	0	0	0		
16.00	Day Care Program	0	0	0	0		
17.00	Home Delivered Meals Program	0	0	0	0		
18.00	Homemaker Service	0	0	0	0		
19.00	All Others (specify)	0	0	0	0		
19.50	Telemedicine	0	0	0	0		
20.00	Total (sum of lines 1-19)	0	0	0	0		
21.00	Total cost to be allocated	0	0	0	0		
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000		

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:39 pm

				Title XVIII		Home Health Agency I		PPS	
Cost Center Description			From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care		2.00	5,718,913		5,718,913	27,647	206.85	1.00
2.00	Physical Therapy		3.00	4,804,467	0	4,804,467	24,432	196.65	2.00
3.00	Occupational Therapy		4.00	966,421	0	966,421	6,057	159.55	3.00
4.00	Speech Pathology		5.00	122,501	0	122,501	874	140.16	4.00
5.00	Medical Social Services		6.00	279,498		279,498	234	1,194.44	5.00
6.00	Home Health Aide		7.00	206,238		206,238	1,467	140.58	6.00
7.00	Total (sum of lines 1-6)			12,098,038	0	12,098,038	60,711		7.00
Program Visits									
Part B									
Cost Center Description			Cost Limits	CBSA No. (1)	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
			0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation									
8.00	Skilled Nursing Care			11180	0	16,314			8.00
8.01	Skilled Nursing Care			16974	0	2			8.01
8.02	Skilled Nursing Care			20994	0	1,702			8.02
8.03	Skilled Nursing Care			22744	0	49			8.03
8.04	Skilled Nursing Care			25540	0	15			8.04
8.05	Skilled Nursing Care			26900	0	1			8.05
8.06	Skilled Nursing Care			29404	0	5			8.06
8.07	Skilled Nursing Care			34940	0	1			8.07
8.08	Skilled Nursing Care			35380	0	32			8.08
8.09	Skilled Nursing Care			36740	0	5			8.09
8.10	Skilled Nursing Care			41740	0	0			8.10
8.11	Skilled Nursing Care			99918	0	9			8.11
9.00	Physical Therapy			11180	0	14,333			9.00
9.01	Physical Therapy			16974	0	4			9.01
9.02	Physical Therapy			20994	0	1,755			9.02
9.03	Physical Therapy			22744	0	9			9.03
9.04	Physical Therapy			25540	0	11			9.04
9.05	Physical Therapy			26900	0	1			9.05
9.06	Physical Therapy			29404	0	1			9.06
9.07	Physical Therapy			34940	0	1			9.07
9.08	Physical Therapy			35380	0	28			9.08
9.09	Physical Therapy			36740	0	0			9.09
9.10	Physical Therapy			41740	0	6			9.10
9.11	Physical Therapy			99918	0	10			9.11
10.00	Occupational Therapy			11180	0	3,700			10.00
10.01	Occupational Therapy			16974	0	1			10.01
10.02	Occupational Therapy			20994	0	433			10.02
10.03	Occupational Therapy			22744	0	4			10.03
10.04	Occupational Therapy			25540	0	0			10.04
10.05	Occupational Therapy			26900	0	0			10.05
10.06	Occupational Therapy			29404	0	0			10.06
10.07	Occupational Therapy			34940	0	0			10.07
10.08	Occupational Therapy			35380	0	21			10.08
10.09	Occupational Therapy			36740	0	0			10.09
10.10	Occupational Therapy			41740	0	0			10.10
10.11	Occupational Therapy			99918	0	5			10.11
11.00	Speech Pathology			11180	0	595			11.00
11.01	Speech Pathology			16974	0	0			11.01
11.02	Speech Pathology			20994	0	75			11.02
11.03	Speech Pathology			22744	0	0			11.03
11.04	Speech Pathology			25540	0	0			11.04
11.05	Speech Pathology			26900	0	0			11.05
11.06	Speech Pathology			29404	0	0			11.06
11.07	Speech Pathology			34940	0	0			11.07
11.08	Speech Pathology			35380	0	0			11.08
11.09	Speech Pathology			36740	0	0			11.09
11.10	Speech Pathology			41740	0	0			11.10
11.11	Speech Pathology			99918	0	0			11.11
12.00	Medical Social Services			11180	0	148			12.00
12.01	Medical Social Services			16974	0	0			12.01
12.02	Medical Social Services			20994	0	15			12.02
12.03	Medical Social Services			22744	0	0			12.03
12.04	Medical Social Services			25540	0	0			12.04

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:39 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
12.05	Medical Social Services		26900	0	0			12.05
12.06	Medical Social Services		29404	0	1			12.06
12.07	Medical Social Services		34940	0	0			12.07
12.08	Medical Social Services		35380	0	0			12.08
12.09	Medical Social Services		36740	0	0			12.09
12.10	Medical Social Services		41740	0	0			12.10
12.11	Medical Social Services		99918	0	0			12.11
13.00	Home Health Aide		11180	0	863			13.00
13.01	Home Health Aide		16974	0	0			13.01
13.02	Home Health Aide		20994	0	233			13.02
13.03	Home Health Aide		22744	0	0			13.03
13.04	Home Health Aide		25540	0	0			13.04
13.05	Home Health Aide		26900	0	0			13.05
13.06	Home Health Aide		29404	0	0			13.06
13.07	Home Health Aide		34940	0	0			13.07
13.08	Home Health Aide		35380	0	0			13.08
13.09	Home Health Aide		36740	0	0			13.09
13.10	Home Health Aide		41740	0	0			13.10
13.11	Home Health Aide		99918	0	0			13.11
14.00	Total (sum of lines 8-13)			0	40,388			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	449,052	64,976	514,028	640,411	0.802653	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		Part A	Part B		Part A	Part B	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
			6.00	7.00				
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	18,135		0	3,751,225		1.00
2.00	Physical Therapy	0	16,159		0	3,177,667		2.00
3.00	Occupational Therapy	0	4,164		0	664,366		3.00
4.00	Speech Pathology	0	670		0	93,907		4.00
5.00	Medical Social Services	0	164		0	195,888		5.00
6.00	Home Health Aide	0	1,096		0	154,076		6.00
7.00	Total (sum of lines 1-6)	0	40,388		0	8,037,129		7.00
Cost Center Description								
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
8.05	Skilled Nursing Care							8.05
8.06	Skilled Nursing Care							8.06
8.07	Skilled Nursing Care							8.07
8.08	Skilled Nursing Care							8.08
8.09	Skilled Nursing Care							8.09
8.10	Skilled Nursing Care							8.10
8.11	Skilled Nursing Care							8.11
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
9.05	Physical Therapy							9.05
9.06	Physical Therapy							9.06
9.07	Physical Therapy							9.07
9.08	Physical Therapy							9.08

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part I
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Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
9.09	Physical Therapy							9.09	
9.10	Physical Therapy							9.10	
9.11	Physical Therapy							9.11	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
10.03	Occupational Therapy							10.03	
10.04	Occupational Therapy							10.04	
10.05	Occupational Therapy							10.05	
10.06	Occupational Therapy							10.06	
10.07	Occupational Therapy							10.07	
10.08	Occupational Therapy							10.08	
10.09	Occupational Therapy							10.09	
10.10	Occupational Therapy							10.10	
10.11	Occupational Therapy							10.11	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
11.03	Speech Pathology							11.03	
11.04	Speech Pathology							11.04	
11.05	Speech Pathology							11.05	
11.06	Speech Pathology							11.06	
11.07	Speech Pathology							11.07	
11.08	Speech Pathology							11.08	
11.09	Speech Pathology							11.09	
11.10	Speech Pathology							11.10	
11.11	Speech Pathology							11.11	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
12.03	Medical Social Services							12.03	
12.04	Medical Social Services							12.04	
12.05	Medical Social Services							12.05	
12.06	Medical Social Services							12.06	
12.07	Medical Social Services							12.07	
12.08	Medical Social Services							12.08	
12.09	Medical Social Services							12.09	
12.10	Medical Social Services							12.10	
12.11	Medical Social Services							12.11	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
13.03	Home Health Aide							13.03	
13.04	Home Health Aide							13.04	
13.05	Home Health Aide							13.05	
13.06	Home Health Aide							13.06	
13.07	Home Health Aide							13.07	
13.08	Home Health Aide							13.08	
13.09	Home Health Aide							13.09	
13.10	Home Health Aide							13.10	
13.11	Home Health Aide							13.11	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B			Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Not Subject to Deductibles & Coinsurance				Subject to Deductibles & Coinsurance
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	426,602	0	0	342,413	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part I
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2/27/2020 12:39 pm

Title XVIII

Home Health
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PPS

Cost Center Description		Total Program Cost (sum of cols. 9-10)		
		12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION				
Cost Per Visit Computation				
1.00	Skilled Nursing Care	3,751,225		1.00
2.00	Physical Therapy	3,177,667		2.00
3.00	Occupational Therapy	664,366		3.00
4.00	Speech Pathology	93,907		4.00
5.00	Medical Social Services	195,888		5.00
6.00	Home Health Aide	154,076		6.00
7.00	Total (sum of lines 1-6)	8,037,129		7.00
Cost Center Description				
		12.00		
Limitation Cost Computation				
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
8.04	Skilled Nursing Care			8.04
8.05	Skilled Nursing Care			8.05
8.06	Skilled Nursing Care			8.06
8.07	Skilled Nursing Care			8.07
8.08	Skilled Nursing Care			8.08
8.09	Skilled Nursing Care			8.09
8.10	Skilled Nursing Care			8.10
8.11	Skilled Nursing Care			8.11
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
9.04	Physical Therapy			9.04
9.05	Physical Therapy			9.05
9.06	Physical Therapy			9.06
9.07	Physical Therapy			9.07
9.08	Physical Therapy			9.08
9.09	Physical Therapy			9.09
9.10	Physical Therapy			9.10
9.11	Physical Therapy			9.11
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
10.04	Occupational Therapy			10.04
10.05	Occupational Therapy			10.05
10.06	Occupational Therapy			10.06
10.07	Occupational Therapy			10.07
10.08	Occupational Therapy			10.08
10.09	Occupational Therapy			10.09
10.10	Occupational Therapy			10.10
10.11	Occupational Therapy			10.11
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
11.04	Speech Pathology			11.04
11.05	Speech Pathology			11.05
11.06	Speech Pathology			11.06
11.07	Speech Pathology			11.07
11.08	Speech Pathology			11.08
11.09	Speech Pathology			11.09
11.10	Speech Pathology			11.10
11.11	Speech Pathology			11.11
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
12.04	Medical Social Services			12.04
12.05	Medical Social Services			12.05
12.06	Medical Social Services			12.06
12.07	Medical Social Services			12.07
12.08	Medical Social Services			12.08
12.09	Medical Social Services			12.09

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2018
To 09/30/2019Part I
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Title XVIII

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Cost Center Description				
		12.00		
12.10	Medical Social Services			12.10
12.11	Medical Social Services			12.11
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
13.04	Home Health Aide			13.04
13.05	Home Health Aide			13.05
13.06	Home Health Aide			13.06
13.07	Home Health Aide			13.07
13.08	Home Health Aide			13.08
13.09	Home Health Aide			13.09
13.10	Home Health Aide			13.10
13.11	Home Health Aide			13.11
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2018

Part II

To 09/30/2019

Date/Time Prepared:

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Title XVIII

Home Health
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PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.326021	0	0	col. 2, line 2.00		1.00
1.01 Physical Therapy 1	66.01	0.375311	0	0	col. 2, line 2.01		1.01
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.250538	259,344	64,976	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.244392	0	0	col. 2, line 16.00		5.00
5.01 Cost of Drugs 1	73.01	0.393807	0	0	col. 2, line 16.01		5.01

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 HHA CCN: 14-7094	Period: From 10/01/2018 To 09/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2020 12:39 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	3,948	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	-3,948	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	7,960,309	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	209,680	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	127,329	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	66,210	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	25,441	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	127	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	8,385,148	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	8,385,148	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	8,385,148	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	8,385,148	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	8,385,148	31.00
31.01	Sequestration adjustment (see instructions)	0	167,963	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	8,217,185	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-0252
HHA CCN: 14-7094Period:
From 10/01/2018
To 09/30/2019Worksheet H-5
Date/Time Prepared:
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		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		0		8,217,185	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		8,217,185	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		8,217,185	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0252	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/27/2020 12:39 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		6,540,982	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		314,268	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)		225.23	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.32	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		13.28	8.00
9.00	Sum of lines 7 and 8		15.60	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.21	10.00
11.00	Disproportionate share adjustment (see instructions)		209,966	11.00
12.00	Total prospective capital payments (see instructions)		7,065,216	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