

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-0289

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

Worksheet S
Parts I-III
Date/Time Prepared:
8/27/2020 3:17 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/27/2020	Time: 3:17 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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 ANDERSON HOSPITAL (14-0289) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-71,881	-21,867	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	19,639	0		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	-52,242	-21,867	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: 14-0289		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 3:17 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 6800 STATE ROUTE 162			PO Box:		1.00			
2.00	City: MARYVILLE			State: IL		Zip Code: 62062-1000		County: MADISON	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			ANDERSON HOSPITAL	140289	41180	1	11/22/1976	N
4.00	Subprovider - IPF							P	N
5.00	Subprovider - IRF			THE REHABILITATION CENTER	14T289	41180	5	01/01/2005	N
6.00	Subprovider - (Other)							P	N
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA			ANDERSON HOME HEALTH	147420	41180	05/30/1985	N	P
13.00	Separately Certified ASC								N
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)						2		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			731	894	0	0	2,569	210

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0289		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 3:17 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			115	38	0	0	276		25.00
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)									37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.									38.00
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	N		40.00
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.				Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/27/2020 3:17 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00	

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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)				
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 3:17 pm	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
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	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N					112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N					115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	857,070		0	1,600,000		118.01
						1.00	
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.	N					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 3:17 pm	
		1.00		2.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 3:17 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0289		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 3:17 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/23/2020	Y	04/23/2020		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/27/2020 3:17 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD, LLP	BKD, LLP		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 3:17 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.	BKD, LLP		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: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 3:17 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	106	38,690	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)		106	38,690	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		130	47,450	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	24	8,760		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
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)		154				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: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 3:17 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)	8,287	571	20,293		1.00
2.00	HMO and other (see instructions)	4,783	3,463			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	662	314			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)	8,287	571	20,293		7.00
8.00	INTENSIVE CARE UNIT	847	70	2,238		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		90	2,907		13.00
14.00	Total (see instructions)	9,134	731	25,438	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF	2,761	115	4,647	0.00	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	3,701	0	8,631	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	942.13
28.00	Observation Bed Days		139	5,525		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	210	508		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: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 3:17 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,272	188	6,725	1.00
2.00 HMO and other (see instructions)			1,055	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,272	188	6,725	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	249	10	398	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
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: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/27/2020 3:17 pm

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	57,377,083	0	57,377,083	1,959,626.00	29.28 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		1,317,384	0	1,317,384	9,648.00	136.54 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		2,687,451	187	2,687,638	81,285.97	33.06 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		575,831	0	575,831	11,551.00	49.85 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		412,000	0	412,000	2,119.00	194.43 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		1,179,056	0	1,179,056	8,635.00	136.54 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,025,883	0	12,025,883		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		554,282	0	554,282		
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)		276,704	0	276,704		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/27/2020 3:17 pm

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	577,953	0	577,953	14,131.00	40.90	26.00
27.00	Administrative & General	5.00	9,238,365	-336,054	8,902,311	303,219.00	29.36	27.00
28.00	Administrative & General under contract (see inst.)		2,641,379	0	2,641,379	41,566.58	63.55	28.00
29.00	Maintenance & Repairs	6.00	1,038,060	0	1,038,060	34,834.00	29.80	29.00
30.00	Operation of Plant	7.00	181,963	0	181,963	2,069.00	87.95	30.00
31.00	Laundry & Linen Service	8.00	62,687	0	62,687	4,174.00	15.02	31.00
32.00	Housekeeping	9.00	1,332,789	0	1,332,789	81,104.00	16.43	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	913,042	-646,187	266,855	17,796.00	15.00	34.00
35.00	Dietary under contract (see instructions)		984,436	0	984,436	11,045.00	89.13	35.00
36.00	Cafeteria	11.00	0	646,187	646,187	43,092.00	15.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	734,711	0	734,711	13,069.00	56.22	38.00
39.00	Central Services and Supply	14.00	779,870	0	779,870	42,564.00	18.32	39.00
40.00	Pharmacy	15.00	1,871,398	-1,871,398	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,117,008	0	1,117,008	52,943.00	21.10	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: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/27/2020 3:17 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	59,685,514	0	59,685,514	2,002,589.58	29.80	1.00
2.00	Excluded area salaries (see instructions)	2,687,451	187	2,687,638	81,285.97	33.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	56,998,063	-187	56,997,876	1,921,303.61	29.67	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,166,887	0	2,166,887	22,305.00	97.15	4.00
5.00	Subtotal wage-related costs (see inst.)	12,302,587	0	12,302,587	0.00	21.58	5.00
6.00	Total (sum of lines 3 thru 5)	71,467,537	-187	71,467,350	1,943,608.61	36.77	6.00
7.00	Total overhead cost (see instructions)	21,473,661	-2,207,452	19,266,209	661,606.58	29.12	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/27/2020 3:17 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,453,012	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	2,496	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)	5,417,837	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	186,856	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	49,134	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)	73,605	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	6,712	14.00
15.00	'Workers' Compensation Insurance	361,880	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	4,402,495	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	69,855	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	74,837	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	172,279	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,270,998	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/27/2020 3:17 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	575,831	12,270,998	1.00
2.00	Hospital	575,831	12,270,998	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	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
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0289 Component CCN: 14-7420		Period: From 01/01/2019 To 12/31/2019		Worksheet S-4 Date/Time Prepared: 8/27/2020 3:17 pm	
						Home Health Agency I		PPS	
						1.00			
0.00	County							0.00	
		Title V	Title XVIII	Title XIX	Other	Total			
		1.00	2.00	3.00	4.00	5.00			
HOME HEALTH AGENCY STATISTICAL DATA									
1.00	Home Health Aide Hours	0	1,282	25	1,508	2,815	1.00		
2.00	Unduplicated Census Count (see instructions)	0.00	247.00	39.00	345.00	0.00	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	0.00	0.00	3.00		
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00		
5.00	Other Administrative Personnel			2.00	0.00	2.00	5.00		
6.00	Direct Nursing Service			3.20	0.00	3.20	6.00		
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00		
8.00	Physical Therapy Service			4.00	0.00	4.00	8.00		
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00		
10.00	Occupational Therapy Service			1.40	0.00	1.40	10.00		
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00		
12.00	Speech Pathology Service			2.00	0.00	2.00	12.00		
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00		
14.00	Medical Social Service			1.00	0.00	1.00	14.00		
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00		
16.00	Home Health Aide			1.70	0.00	1.70	16.00		
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00		
18.00	MANAGER			1.00	0.00	1.00	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.			1			19.00		
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			41180			20.00		
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)			
		Without Outliers	With Outliers						
		1.00	2.00	3.00	4.00	5.00			
PPS ACTIVITY DATA									
21.00	Skilled Nursing Visits	1,207	229	124	49	1,609	21.00		
22.00	Skilled Nursing Visit Charges	209,534	39,915	21,555	8,541	279,545	22.00		
23.00	Physical Therapy Visits	1,082	42	18	48	1,190	23.00		
24.00	Physical Therapy Visit Charges	188,252	7,321	3,137	8,366	207,076	24.00		
25.00	Occupational Therapy Visits	458	31	10	29	528	25.00		
26.00	Occupational Therapy Visit Charges	79,605	5,403	1,743	4,706	91,457	26.00		
27.00	Speech Pathology Visits	107	32	1	3	143	27.00		
28.00	Speech Pathology Visit Charges	18,542	5,578	174	523	24,817	28.00		
29.00	Medical Social Service Visits	2	0	0	2	4	29.00		
30.00	Medical Social Service Visit Charges	463	0	0	463	926	30.00		
31.00	Home Health Aide Visits	179	32	1	15	227	31.00		
32.00	Home Health Aide Visit Charges	16,562	2,963	93	1,389	21,007	32.00		
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,035	366	154	146	3,701	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)	512,958	61,180	26,702	23,988	624,828	35.00		
36.00	Total Number of Episodes (standard/non outlier)	229		52	12	293	36.00		
37.00	Total Number of Outlier Episodes		12		1	13	37.00		
38.00	Total Non-Routine Medical Supply Charges	9,201	4,878	1,522	1,061	16,662	38.00		

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/27/2020 3:17 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)			0.206643	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			14,699,872	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			3,996,944	5.00
6.00	Medicaid charges			97,733,129	6.00
7.00	Medicaid cost (line 1 times line 6)			20,195,867	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,499,051	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,499,051	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,892,320	2,775,344	5,667,664	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	597,678	2,775,344	3,373,022	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	597,678	2,775,344	3,373,022	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			6,866,046	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			403,983	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			621,512	27.01
28.00	Non-Medicare bad debt expense (see instructions)			6,244,534	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,507,918	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,880,940	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,379,991	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0289

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

Worksheet A

Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		3,436,549	3,436,549	1,424,507	4,861,056	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,388,397	3,388,397	409,202	3,797,599	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	577,953	13,465,417	14,043,370	-151,390	13,891,980	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,238,365	25,087,147	34,325,512	-919,541	33,405,971	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,038,060	875,357	1,913,417	-196	1,913,221	6.00
7.00	00700	OPERATION OF PLANT	181,963	2,027,424	2,209,387	45,885	2,255,272	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	62,687	514,983	577,670	-11	577,659	8.00
9.00	00900	HOUSEKEEPING	1,332,789	267,116	1,599,905	-10,214	1,589,691	9.00
10.00	01000	DIETARY	913,042	1,030,037	1,943,079	-1,361,484	581,595	10.00
11.00	01100	CAFETERIA	0	0	0	1,361,360	1,361,360	11.00
13.00	01300	NURSING ADMINISTRATION	734,711	284,136	1,018,847	-281,067	737,780	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	779,870	580,749	1,360,619	-469,304	891,315	14.00
15.00	01500	PHARMACY	1,871,398	5,950,070	7,821,468	-1,959,168	5,862,300	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,117,008	494,918	1,611,926	-22	1,611,904	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	172,023	1,131	173,154	-155	172,999	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,796,287	1,035,057	12,831,344	-3,237,124	9,594,220	30.00
31.00	03100	INTENSIVE CARE UNIT	2,174,148	349,525	2,523,673	-18,668	2,505,005	31.00
41.00	04100	SUBPROVIDER - IRF	1,372,703	804,693	2,177,396	-3,666	2,173,730	41.00
43.00	04300	NURSERY	0	0	0	1,300,799	1,300,799	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,313,545	9,099,775	14,413,320	-6,949,602	7,463,718	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,635,857	1,635,857	52.00
53.00	05300	ANESTHESIOLOGY	0	332,182	332,182	-53,765	278,417	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,267,776	1,236,320	3,504,096	83,436	3,587,532	54.00
56.00	05600	RADIOISOTOPE	163,047	395,215	558,262	-289,021	269,241	56.00
57.00	05700	CT SCAN	416,810	694,896	1,111,706	-253,074	858,632	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	170,033	441,993	612,026	-54,339	557,687	58.00
59.00	05900	CARDIAC CATHETERIZATION	803,487	1,652,172	2,455,659	-1,179,002	1,276,657	59.00
60.00	06000	LABORATORY	1,662,271	3,465,642	5,127,913	0	5,127,913	60.00
65.00	06500	RESPIRATORY THERAPY	1,164,863	433,561	1,598,424	-186,984	1,411,440	65.00
66.00	06600	PHYSICAL THERAPY	1,456,558	328,845	1,785,403	-51,671	1,733,732	66.00
67.00	06700	OCCUPATIONAL THERAPY	927,624	28,503	956,127	115,522	1,071,649	67.00
68.00	06800	SPEECH PATHOLOGY	665,978	26,809	692,787	60,756	753,543	68.00
68.01	03040	AUDIOLOGY	161,360	170,433	331,793	-148,614	183,179	68.01
69.00	06900	ELECTROCARDIOLOGY	528,392	224,203	752,595	-14,343	738,252	69.00
69.01	03160	CARDIOPULMONARY	536,179	77,434	613,613	-34,307	579,306	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70,646	8,429	79,075	-6,396	72,679	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,564,843	10,564,843	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,866,210	1,866,210	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	281,067	281,067	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	861,356	9,754,250	10,615,606	-104,634	10,510,972	90.00
91.00	09100	EMERGENCY	5,701,426	951,206	6,652,632	-248,663	6,403,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,142,725	108,571	1,251,296	-16,290	1,235,006	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,146,729	1,146,729	-1,146,729	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,377,083	90,169,874	147,546,957	0	147,546,957	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	57,377,083	90,169,874	147,546,957	0	147,546,957	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0289

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

Worksheet A

Date/Time Prepared:
8/27/2020 3:17 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	-826,258	4,034,798	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-332,449	3,465,150	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-89,387	13,802,593	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,180,745	21,225,226	5.00
6.00	00600	MAINTENANCE & REPAIRS	-18,901	1,894,320	6.00
7.00	00700	OPERATION OF PLANT	-28,978	2,226,294	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	577,659	8.00
9.00	00900	HOUSEKEEPING	0	1,589,691	9.00
10.00	01000	DIETARY	0	581,595	10.00
11.00	01100	CAFETERIA	0	1,361,360	11.00
13.00	01300	NURSING ADMINISTRATION	-22,575	715,205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	891,315	14.00
15.00	01500	PHARMACY	0	5,862,300	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-94,477	1,517,427	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	172,999	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	9,594,220	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,505,005	31.00
41.00	04100	SUBPROVIDER - IRF	0	2,173,730	41.00
43.00	04300	NURSERY	0	1,300,799	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	7,463,718	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-57	1,635,800	52.00
53.00	05300	ANESTHESIOLOGY	-72,679	205,738	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-63,527	3,524,005	54.00
56.00	05600	RADIOISOTOPE	0	269,241	56.00
57.00	05700	CT SCAN	0	858,632	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	557,687	58.00
59.00	05900	CARDIAC CATHETERIZATION	-10,429	1,266,228	59.00
60.00	06000	LABORATORY	0	5,127,913	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,411,440	65.00
66.00	06600	PHYSICAL THERAPY	0	1,733,732	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,071,649	67.00
68.00	06800	SPEECH PATHOLOGY	0	753,543	68.00
68.01	03040	AUDIOLOGY	-56,009	127,170	68.01
69.00	06900	ELECTROCARDIOLOGY	0	738,252	69.00
69.01	03160	CARDIOPULMONARY	-12,897	566,409	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	72,679	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,564,843	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,866,210	73.00
74.00	07400	RENAL DIALYSIS	0	281,067	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-9,515	10,501,457	90.00
91.00	09100	EMERGENCY	-9,001	6,394,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,235,006	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,827,884	133,719,073	118.00
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
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,827,884	133,719,073	200.00

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
8/27/2020 3:17 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS INTEREST EXPENSE TO CAPTL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	826,258	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	320,471	2.00	
			0	1,146,729		
	B - TO RECLASS EXPENSES FOR CAFETERIA					
1.00	CAFETERIA	11.00	646,187	715,173	1.00	
			646,187	715,173		
	C - L&D/NURSERY RECLASS					
1.00	NURSERY	43.00	1,179,925	174,605	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,577,058	130,636	2.00	
			2,756,983	305,241		
	E - TO RECLASS ELECTRICITY EXP					
1.00	OPERATION OF PLANT	7.00	0	72,794	1.00	
2.00		0.00	0	0	2.00	
			0	72,794		
	F - TO RECLASS TELEPHONE EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,839	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
			0	15,839		
	G - TO RECLASS RENAL DIALYSIS EXP					
1.00	RENAL DIALYSIS	74.00	0	281,067	1.00	
			0	281,067		
	H - INSURANCE EXPENSE					
1.00	OTHER CAP REL COSTS	3.00	0	147,254	1.00	
			0	147,254		
	J - TO RECLASS MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,564,843	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
			0	10,564,843		
	K - TO RECLASS REAL ESTATE TAXES					
1.00	OTHER CAP REL COSTS	3.00	0	158,005	1.00	
			0	158,005		
	L - TO RECLASS PHYSICIAN OFFICE LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	381,721	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
			0	381,721		
	M - TO RECLASS PROF RENUMERATION					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	200,000	1.00	
2.00	ANESTHESIOLOGY	53.00	0	175,000	2.00	
			0	375,000		

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	N - TO RECLASS PENSION AUDIT COSTS					1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,496		
	0		0	2,496		
	O - TO RECLASS REHAB ADMIN EXP					
1.00	SPEECH PATHOLOGY	68.00	56,257	4,566	1.00	
2.00	AUDIOLOGY	68.01	14,330	1,163	2.00	
3.00	OCCUPATIONAL THERAPY	67.00	107,549	8,730	3.00	
4.00	PHYSICAL THERAPY	66.00	157,918	12,818	4.00	
	0		336,054	27,277		
	P - TO RECLASS PHARMACISTS SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	3,743	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	512	0	2.00	
3.00	SUBPROVIDER - IRF	41.00	187	0	3.00	
4.00	NURSERY	43.00	68	0	4.00	
5.00	OPERATING ROOM	50.00	289	0	5.00	
6.00	DELIVERY ROOM & LABOR ROOM	52.00	91	0	6.00	
7.00	CARDIAC CATHETERIZATION	59.00	85	0	7.00	
8.00	DRUGS CHARGED TO PATIENTS	73.00	1,866,210	0	8.00	
9.00	EMERGENCY	91.00	213	0	9.00	
	0		1,871,398	0		
	Q - TO RECLASS CABLE TB EXPS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,978	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	0		0	28,978		
	R - LEGAL EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	153,886	1.00	
	TOTALS		0	153,886		
500.00	Grand Total: Increases		5,610,622	14,376,303	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
8/27/2020 3:17 pm

	Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE TO CAPTL						
1.00	INTEREST EXPENSE	113.00	0	1,146,729	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,146,729			
	B - TO RECLASS EXPENSES FOR CAFETERIA						
1.00	DIETARY	10.00	646,187	715,173	0		1.00
	0		646,187	715,173			
	C - L&D/NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	2,756,983	305,241	0		1.00
2.00		0.00	0	0	0		2.00
	0		2,756,983	305,241			
	E - TO RECLASS ELECTRICITY EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	96	0		1.00
2.00	CLINIC	90.00	0	72,698	0		2.00
	0		0	72,794			
	F - TO RECLASS TELEPHONE EXP						
1.00	OPERATION OF PLANT	7.00	0	154	0		1.00
2.00	CLINIC	90.00	0	1,162	0		2.00
3.00	EMERGENCY	91.00	0	11,281	0		3.00
4.00	HOME HEALTH AGENCY	101.00	0	3,242	0		4.00
	0		0	15,839			
	G - TO RECLASS RENAL DIALYSIS EXP						
1.00	NURSING ADMINISTRATION	13.00	0	281,067	0		1.00
	0		0	281,067			
	H - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	147,254	12		1.00
	0		0	147,254			
	J - TO RECLASS MED SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,916	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	100	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	11	0		3.00
4.00	HOUSEKEEPING	9.00	0	10,214	0		4.00
5.00	DIETARY	10.00	0	124	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	469,304	0		6.00
7.00	PHARMACY	15.00	0	87,770	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	22	0		8.00
9.00	PARAMEDICAL EDUCATION PRGM	23.00	0	155	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	178,643	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	19,180	0		11.00
12.00	SUBPROVIDER - IRF	41.00	0	3,853	0		12.00
13.00	NURSERY	43.00	0	53,799	0		13.00
14.00	OPERATING ROOM	50.00	0	6,949,891	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	71,928	0		15.00
16.00	ANESTHESIOLOGY	53.00	0	228,765	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	116,564	0		17.00
18.00	RADIOISOTOPE	56.00	0	289,021	0		18.00
19.00	CT SCAN	57.00	0	253,074	0		19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	54,339	0		20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	1,179,087	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	186,984	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	3,227	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	757	0		24.00
25.00	SPEECH PATHOLOGY	68.00	0	67	0		25.00
26.00	AUDIOLOGY	68.01	0	164,107	0		26.00
27.00	ELECTROCARDIOLOGY	69.00	0	14,343	0		27.00
28.00	CARDIOPULMONARY	69.01	0	34,307	0		28.00
29.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,396	0		29.00
30.00	CLINIC	90.00	0	28,647	0		30.00
31.00	EMERGENCY	91.00	0	145,200	0		31.00
32.00	HOME HEALTH AGENCY	101.00	0	13,048	0		32.00
	0		0	10,564,843			
	K - TO RECLASS REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	158,005	0		1.00
	0		0	158,005			
	L - TO RECLASS PHYSICIAN OFFICE LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	70,146	10		1.00
2.00	PHYSICAL THERAPY	66.00	0	219,180	0		2.00
3.00	EMERGENCY	91.00	0	92,395	0		3.00
	0		0	381,721			
	M - TO RECLASS PROF RENUMERATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	375,000	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	375,000			

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
8/27/2020 3:17 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	N - TO RECLASS PENSION AUDIT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,496	0		1.00
	0		0	2,496			
	O - TO RECLASS REHAB ADMIN EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	336,054	27,277	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
	0		336,054	27,277			
	P - TO RECLASS PHARMACISTS SALARIES						
1.00	PHARMACY	15.00	1,871,398	0	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
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		1,871,398	0			
	Q - TO RECLASS CABLE TB EXPS						
1.00	CLINIC	90.00	0	2,127	0		1.00
2.00	OPERATION OF PLANT	7.00	0	26,755	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	96	0		3.00
	0		0	28,978			
	R - LEGAL EXPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	153,886	0		1.00
	TOTALS		0	153,886			
500.00	Grand Total: Decreases		5,610,622	14,376,303			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/27/2020 3:17 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	963,454	0	0	0	0	1.00
2.00	Land Improvements	3,151,148	16,423	0	16,423	15,300	2.00
3.00	Buildings and Fixtures	118,477,016	11,795,677	0	11,795,677	19,393,918	3.00
4.00	Building Improvements	24,000	0	0	0	0	4.00
5.00	Fixed Equipment	5,579,800	62,926	0	62,926	236,212	5.00
6.00	Movable Equipment	42,424,095	15,055,348	0	15,055,348	8,134,067	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	170,619,513	26,930,374	0	26,930,374	27,779,497	8.00
9.00	Reconciling Items	6,478,521	9,548,356	0	9,548,356	16,019,197	9.00
10.00	Total (line 8 minus line 9)	164,140,992	17,382,018	0	17,382,018	11,760,300	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	963,454	0				1.00
2.00	Land Improvements	3,152,271	0				2.00
3.00	Buildings and Fixtures	110,878,775	0				3.00
4.00	Building Improvements	24,000	0				4.00
5.00	Fixed Equipment	5,406,514	0				5.00
6.00	Movable Equipment	49,345,376	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	169,770,390	0				8.00
9.00	Reconciling Items	7,680	0				9.00
10.00	Total (line 8 minus line 9)	169,762,710	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/27/2020 3:17 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	3,436,549	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,312,322	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,748,871	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	3,436,549				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	76,075	3,388,397				2.00
3.00	Total (sum of lines 1-2)	76,075	6,824,946				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/27/2020 3:17 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	120,417,334	0	120,417,334	0.709327	104,451	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,345,376	0	49,345,376	0.290673	42,803	2.00
3.00	Total (sum of lines 1-2)	169,762,710	0	169,762,710	1.000000	147,254	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed 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	112,077	0	216,528	3,436,549	381,721	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	45,928	0	88,731	3,300,344	0	2.00
3.00	Total (sum of lines 1-2)	158,005	0	305,259	6,736,893	381,721	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	104,451	112,077	0	4,034,798	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	42,803	45,928	76,075	3,465,150	2.00
3.00	Total (sum of lines 1-2)	0	147,254	158,005	76,075	7,499,948	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0289

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 3:17 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	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-826,258	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-320,471	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-62	ADMINISTRATIVE & GENERAL	5.00	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	-15,030	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-28,978	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	-3,849,899			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	-182,769			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-69,871	MEDICAL RECORDS & LIBRARY	16.00	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	B	-1,818	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0289

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER MISC INCOME	B	-198,852	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REVENUE CR CARD SHARING REV	B	-59,657	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MANAGEMENT FEES	B	-180,000	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	EDUCATION CLASSES - VARIOUS	B	-1,463	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OB LACTATION REVENUE	B	-57	DELIVERY ROOM & LABOR ROOM	52.00	0	33.04
33.05	AH OTHER REVENUE HEALTH MGM	B	-12,897	CARDIOPULMONARY	69.01	0	33.05
33.06	SALES TAX REVERSAL	A	-24	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITMENT	A	-133,003	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING PORTION OF DUES	A	-32,239	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ENTERTAINMENT EXPENSE	A	-24,150	MEDICAL RECORDS & LIBRARY	16.00	0	33.09
33.10	PROMOTIONAL ITEMS	A	-16,891	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PUBLICITY SALARIES	A	-77,938	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PUBLICITY EXPENSES	A	-368,292	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PUBLICITY BENEFITS	A	-17,483	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	DONATION EXPENSE	A	-2,500	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	DONATION EXPENSE	A	-54,209	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PROVIDER TAX OFFSET	A	-6,841,122	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	ADVERTISING EXPENSE	A	-36,941	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	ADVERTISING EXPENSE	A	-248,509	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	ADVERTISING EXPENSE	A	-456	MEDICAL RECORDS & LIBRARY	16.00	0	33.19
33.20	ADVERTISING EXPENSE	A	-9,515	CLINIC	90.00	0	33.20
33.21	AUDIOLOGY REVENUE	B	-56,009	AUDIOLOGY	68.01	0	33.21
33.22	INCORPORATION COSTS-SURGERY CENTER	A	-160,521	ADMINISTRATIVE & GENERAL	5.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,827,884				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0289

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 3:17 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		2.00	CAP REL COSTS-MVBLE EQUIP	102,092	114,070	1.00
2.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	276,704	309,167	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	825,533	922,385	3.00
4.00		6.00	MAINTENANCE & REPAIRS	161,105	180,006	4.00
4.01		13.00	NURSING ADMINISTRATION	192,417	214,992	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,557,851	1,740,620	5.00

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

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

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

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

6.00	B		0.00	ANDERSON HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0289

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 3:17 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-11,978	9		1.00
2.00	-32,463	0		2.00
3.00	-96,852	0		3.00
4.00	-18,901	0		4.00
4.01	-22,575	0		4.01
5.00	-182,769			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	HEALTH CARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0289

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

Worksheet A-8-2

Date/Time Prepared:
8/27/2020 3:17 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	3,700,669	3,688,669	12,000	211,500	63	1.00
2.00	53.00	ANESTHESIOLOGY	175,000	0	175,000	239,400	889	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	200,000	0	200,000	271,900	1,044	3.00
4.00	59.00	CARDIAC CATHETERIZATION	25,000	0	25,000	246,400	123	4.00
5.00	91.00	EMERGENCY	9,001	9,001	0	211,500	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,109,670	3,697,670	412,000		2,119	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	6,406	320	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	102,321	5,116	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	136,473	6,824	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	14,571	729	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			259,771	12,989	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	6,406	5,594	3,694,263		1.00
2.00	53.00	ANESTHESIOLOGY	0	102,321	72,679	72,679		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	136,473	63,527	63,527		3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	14,571	10,429	10,429		4.00
5.00	91.00	EMERGENCY	0	0	0	9,001		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	259,771	152,229	3,849,899		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,034,798	4,034,798			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,465,150		3,465,150		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,802,593	11,175	26,224	13,839,992	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,225,226	323,674	1,077,075	2,153,147	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,894,320	25,922	126,072	253,287	6.00
7.00	00700	OPERATION OF PLANT	2,226,294	323,459	275,113	44,399	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	577,659	3,832	0	15,296	8.00
9.00	00900	HOUSEKEEPING	1,589,691	26,540	12,493	325,201	9.00
10.00	01000	DIETARY	581,595	93,839	5,494	65,113	10.00
11.00	01100	CAFETERIA	1,361,360	0	13,299	157,670	11.00
13.00	01300	NURSING ADMINISTRATION	715,205	24,857	0	179,269	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	891,315	94,735	51,204	190,288	14.00
15.00	01500	PHARMACY	5,862,300	22,099	48,958	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,517,427	79,065	1,879	272,550	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	172,999	0	0	41,974	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,594,220	353,159	85,496	2,206,522	30.00
31.00	03100	INTENSIVE CARE UNIT	2,505,005	82,405	48,853	530,617	31.00
41.00	04100	SUBPROVIDER - IRF	2,173,730	63,440	63,766	334,985	41.00
43.00	04300	NURSERY	1,300,799	9,151	32,145	287,918	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,463,718	281,204	315,398	1,296,575	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,635,800	275,993	42,965	384,824	52.00
53.00	05300	ANESTHESIOLOGY	205,738	0	6,265	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,524,005	19,950	252,326	553,337	54.00
56.00	05600	RADIOISOTOPE	269,241	9,742	8,587	39,783	56.00
57.00	05700	CT SCAN	858,632	129,835	236,603	101,702	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	557,687	26,997	23,230	41,488	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,266,228	0	202,958	196,072	59.00
60.00	06000	LABORATORY	5,127,913	81,859	200,468	405,594	60.00
65.00	06500	RESPIRATORY THERAPY	1,411,440	53,814	41,836	284,227	65.00
66.00	06600	PHYSICAL THERAPY	1,733,732	131,491	13,205	369,127	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,071,649	263,296	2,950	229,837	67.00
68.00	06800	SPEECH PATHOLOGY	753,543	98,719	751	188,741	68.00
68.01	03040	AUDIOLOGY	127,170	4,128	2,369	77,904	68.01
69.00	06900	ELECTROCARDIOLOGY	738,252	0	45,419	128,928	69.00
69.01	03160	CARDIOPULMONARY	566,409	43,365	15,258	130,828	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	72,679	0	5,418	17,238	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,564,843	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,866,210	0	0	455,355	73.00
74.00	07400	RENAL DIALYSIS	281,067	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,501,457	96,875	171,438	210,171	90.00
91.00	09100	EMERGENCY	6,394,968	263,153	9,635	1,391,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,235,006	16,547	0	278,825	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,719,073	3,334,320	3,465,150	13,839,992	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,019	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	408,546	0	0	192.00
193.00	19300	NONPAID WORKERS	0	272,913	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	133,719,073	4,034,798	3,465,150	13,839,992	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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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	24,779,122					5.00
6.00	00600	MAINTENANCE & REPAIRS	523,060	2,822,661				6.00
7.00	00700	OPERATION OF PLANT	652,634	248,505	3,770,404			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	135,743	2,944	4,313	739,787		8.00
9.00	00900	HOUSEKEEPING	444,434	20,390	29,866	0	2,448,615	9.00
10.00	01000	DIETARY	169,692	72,094	105,597	0	0	10.00
11.00	01100	CAFETERIA	348,539	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	209,108	19,097	27,971	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	279,213	72,782	106,605	10,555	15,096	14.00
15.00	01500	PHARMACY	1,349,584	16,978	24,868	0	29,248	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	425,554	60,744	88,972	0	28,069	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	48,897	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,783,904	271,323	397,411	260,693	840,422	30.00
31.00	03100	INTENSIVE CARE UNIT	720,329	63,309	92,730	39,936	324,328	31.00
41.00	04100	SUBPROVIDER - IRF	599,559	48,739	71,389	0	221,722	41.00
43.00	04300	NURSERY	370,758	7,031	10,298	0	83,971	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,128,291	216,042	316,440	108,209	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	532,154	212,038	310,575	75,270	112,276	52.00
53.00	05300	ANESTHESIOLOGY	48,222	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	989,351	15,327	22,450	20,657	71,234	54.00
56.00	05600	RADIOISOTOPE	74,459	7,485	10,963	2,198	7,548	56.00
57.00	05700	CT SCAN	301,784	99,749	146,103	35,095	121,004	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	147,711	20,741	30,379	6,244	21,465	58.00
59.00	05900	CARDIAC CATHETERIZATION	378,775	0	0	8,503	0	59.00
60.00	06000	LABORATORY	1,322,852	62,890	92,116	0	44,344	60.00
65.00	06500	RESPIRATORY THERAPY	407,448	41,344	60,557	0	44,109	65.00
66.00	06600	PHYSICAL THERAPY	511,222	101,021	147,967	4,284	102,841	66.00
67.00	06700	OCCUPATIONAL THERAPY	356,592	202,283	296,288	53,278	4,010	67.00
68.00	06800	SPEECH PATHOLOGY	236,954	75,843	111,089	1,526	2,123	68.00
68.01	03040	AUDIOLOGY	48,123	3,171	4,645	389	472	68.01
69.00	06900	ELECTROCARDIOLOGY	207,577	0	0	4,855	0	69.00
69.01	03160	CARDIOPULMONARY	171,926	33,316	48,799	0	12,737	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	21,685	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,403,047	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	528,056	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	63,931	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,497,464	74,426	109,013	0	0	90.00
91.00	09100	EMERGENCY	1,833,066	202,173	296,126	108,095	361,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	348,095	12,713	18,621	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,619,793	2,284,498	2,982,151	739,787	2,448,615	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,326	14,611	21,402	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,927	313,880	459,742	0	0	192.00
193.00	19300	NONPAID WORKERS	62,076	209,672	307,109	0	0	193.00
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)	24,779,122	2,822,661	3,770,404	739,787	2,448,615	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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	1,093,424					10.00
11.00	01100	CAFETERIA	0	1,880,868				11.00
13.00	01300	NURSING ADMINISTRATION	0	189,706	1,365,213			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,219	0	1,792,012		14.00
15.00	01500	PHARMACY	0	57,506	0	2,144	7,413,685	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	123,473	0	8	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	63,718	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	821,508	459,632	435,642	43,413	14,830	30.00
31.00	03100	INTENSIVE CARE UNIT	88,383	116,766	80,946	20,949	2,029	31.00
41.00	04100	SUBPROVIDER - IRF	183,533	85,059	62,041	2,980	741	41.00
43.00	04300	NURSERY	0	32,164	47,210	5,700	270	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	60,174	228,632	66,329	1,144	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	42,987	63,190	7,621	361	52.00
53.00	05300	ANESTHESIOLOGY	0	30,487	0	5,912	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,124	0	3,144	0	54.00
56.00	05600	RADIOISOTOPE	0	3,011	0	305	0	56.00
57.00	05700	CT SCAN	0	47,789	0	8,456	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,498	0	206	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	27,678	2,294	340	59.00
60.00	06000	LABORATORY	0	69,244	0	205,327	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	64,595	0	9,290	0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,436	74,888	946	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,262	50,970	528	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,936	26,634	210	0	68.00
68.01	03040	AUDIOLOGY	0	1,753	0	333	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	28,315	0	947	0	69.00
69.01	03160	CARDIOPULMONARY	0	57,202	23,083	985	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	43	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,354,872	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,393,125	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	17,141	0	90.00
91.00	09100	EMERGENCY	0	164,212	244,299	31,505	845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	424	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)	1,093,424	1,854,268	1,365,213	1,792,012	7,413,685	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	26,600	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,093,424	1,880,868	1,365,213	1,792,012	7,413,685	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	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
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	2,597,741					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	327,588			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	262,649	0	0	18,830,824	0	30.00
31.00	03100	INTENSIVE CARE UNIT	23,552	0	0	4,740,137	0	31.00
41.00	04100	SUBPROVIDER - IRF	33,316	0	0	3,945,000	0	41.00
43.00	04300	NURSERY	15,848	0	0	2,203,263	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	309,802	0	0	12,791,958	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,196	0	0	3,717,250	0	52.00
53.00	05300	ANESTHESIOLOGY	53,678	0	0	350,302	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164,812	0	0	5,664,717	0	54.00
56.00	05600	RADIOISOTOPE	17,516	0	0	450,838	0	56.00
57.00	05700	CT SCAN	280,019	0	0	2,366,771	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	49,802	0	0	934,448	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,729	0	0	2,128,577	0	59.00
60.00	06000	LABORATORY	327,367	0	0	7,939,974	0	60.00
65.00	06500	RESPIRATORY THERAPY	67,515	0	0	2,486,175	0	65.00
66.00	06600	PHYSICAL THERAPY	50,636	0	0	3,260,796	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,739	0	0	2,579,682	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,297	0	0	1,516,366	0	68.00
68.01	03040	AUDIOLOGY	4,465	0	0	274,922	0	68.01
69.00	06900	ELECTROCARDIOLOGY	72,716	0	0	1,227,009	0	69.00
69.01	03160	CARDIOPULMONARY	7,311	0	0	1,111,219	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9,617	0	0	126,680	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,101	0	0	14,419,863	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	235,859	0	0	10,478,605	0	73.00
74.00	07400	RENAL DIALYSIS	932	0	0	345,930	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	67,613	0	0	13,745,598	0	90.00
91.00	09100	EMERGENCY	324,570	0	327,588	11,953,031	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,084	0	0	1,916,315	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,597,741	0	327,588	131,506,250	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	59,358	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,301,695	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	851,770	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,597,741	0	327,588	133,719,073	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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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
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
23.00	02300	PARAMEDICAL EDUCATION PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	03040	AUDIOLOGY	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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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	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,175	26,224	37,399	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	191,795	323,674	1,077,075	1,592,544	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	25,922	126,072	151,994	6.00
7.00	00700	OPERATION OF PLANT	0	323,459	275,113	598,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,832	0	3,832	8.00
9.00	00900	HOUSEKEEPING	0	26,540	12,493	39,033	9.00
10.00	01000	DIETARY	575	93,839	5,494	99,908	10.00
11.00	01100	CAFETERIA	0	0	13,299	13,299	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,857	0	24,857	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,630	94,735	51,204	218,569	14.00
15.00	01500	PHARMACY	249,838	22,099	48,958	320,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	79,065	1,879	80,944	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	0	113	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	353,159	85,496	438,655	30.00
31.00	03100	INTENSIVE CARE UNIT	0	82,405	48,853	131,258	31.00
41.00	04100	SUBPROVIDER - IRF	164	63,440	63,766	127,370	41.00
43.00	04300	NURSERY	0	9,151	32,145	41,296	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	126,815	281,204	315,398	723,417	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	275,993	42,965	318,958	52.00
53.00	05300	ANESTHESIOLOGY	0	0	6,265	6,265	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	410,697	19,950	252,326	682,973	54.00
56.00	05600	RADIOISOTOPE	0	9,742	8,587	18,329	56.00
57.00	05700	CT SCAN	125,443	129,835	236,603	491,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,554	26,997	23,230	280,781	58.00
59.00	05900	CARDIAC CATHETERIZATION	232,883	0	202,958	435,841	59.00
60.00	06000	LABORATORY	14,612	81,859	200,468	296,939	60.00
65.00	06500	RESPIRATORY THERAPY	35,893	53,814	41,836	131,543	65.00
66.00	06600	PHYSICAL THERAPY	0	131,491	13,205	144,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	263,296	2,950	266,246	67.00
68.00	06800	SPEECH PATHOLOGY	0	98,719	751	99,470	68.00
68.01	03040	AUDIOLOGY	0	4,128	2,369	6,497	68.01
69.00	06900	ELECTROCARDIOLOGY	25,920	0	45,419	71,339	69.00
69.01	03160	CARDIOPULMONARY	0	43,365	15,258	58,623	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	5,418	5,418	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,230	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	770,096	96,875	171,438	1,038,409	90.00
91.00	09100	EMERGENCY	0	263,153	9,635	272,788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	16,547	0	16,547	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,487,915	3,334,320	3,465,150	9,287,385	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,019	0	19,019	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	408,546	0	408,546	192.00
193.00	19300	NONPAID WORKERS	0	272,913	0	272,913	193.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,487,915	4,034,798	3,465,150	9,987,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,598,359					5.00
6.00	00600	MAINTENANCE & REPAIRS	33,740	186,418				6.00
7.00	00700	OPERATION OF PLANT	42,098	16,412	657,202			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,756	194	752	13,575		8.00
9.00	00900	HOUSEKEEPING	28,668	1,347	5,206	0	75,132	9.00
10.00	01000	DIETARY	10,946	4,761	18,406	0	0	10.00
11.00	01100	CAFETERIA	22,482	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	13,488	1,261	4,876	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,010	4,807	18,582	194	463	14.00
15.00	01500	PHARMACY	87,054	1,121	4,335	0	897	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,450	4,012	15,508	450	861	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	3,154	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	179,569	17,919	69,271	4,782	25,787	30.00
31.00	03100	INTENSIVE CARE UNIT	46,464	4,181	16,163	733	9,951	31.00
41.00	04100	SUBPROVIDER - IRF	38,674	3,219	12,444	0	6,803	41.00
43.00	04300	NURSERY	23,916	464	1,795	0	2,577	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	137,284	14,268	55,157	1,986	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,326	14,004	54,135	1,381	3,445	52.00
53.00	05300	ANESTHESIOLOGY	3,111	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,818	1,012	3,913	379	2,186	54.00
56.00	05600	RADIOISOTOPE	4,803	494	1,911	40	232	56.00
57.00	05700	CT SCAN	19,466	6,588	25,467	644	3,713	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,528	1,370	5,295	115	659	58.00
59.00	05900	CARDIAC CATHETERIZATION	24,433	0	0	156	0	59.00
60.00	06000	LABORATORY	85,330	4,153	16,056	0	1,361	60.00
65.00	06500	RESPIRATORY THERAPY	26,282	2,731	10,555	0	1,353	65.00
66.00	06600	PHYSICAL THERAPY	32,976	6,672	25,792	79	3,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,002	13,359	51,645	978	123	67.00
68.00	06800	SPEECH PATHOLOGY	15,285	5,009	19,363	28	65	68.00
68.01	03040	AUDIOLOGY	3,104	209	810	7	14	68.01
69.00	06900	ELECTROCARDIOLOGY	13,390	0	0	89	0	69.00
69.01	03160	CARDIOPULMONARY	11,090	2,200	8,506	0	391	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,399	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	155,007	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,062	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,124	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	161,098	4,915	19,002	0	0	90.00
91.00	09100	EMERGENCY	118,241	13,352	51,616	1,984	11,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	22,454	840	3,246	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,588,082	150,874	519,807	13,575	75,132	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	279	965	3,730	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,994	20,732	80,134	0	0	192.00
193.00	19300	NONPAID WORKERS	4,004	13,847	53,531	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,598,359	186,418	657,202	13,575	75,132	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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	134,197					10.00
11.00	01100	CAFETERIA	0	36,207				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,652	48,618			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,544	0	262,683		14.00
15.00	01500	PHARMACY	0	1,107	0	314	415,723	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,377	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	1,227	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	100,825	8,848	15,515	6,364	832	30.00
31.00	03100	INTENSIVE CARE UNIT	10,847	2,248	2,883	3,071	114	31.00
41.00	04100	SUBPROVIDER - IRF	22,525	1,637	2,209	437	42	41.00
43.00	04300	NURSERY	0	619	1,681	836	15	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,158	8,142	9,723	64	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	828	2,250	1,117	20	52.00
53.00	05300	ANESTHESIOLOGY	0	587	0	867	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	541	0	461	0	54.00
56.00	05600	RADIOISOTOPE	0	58	0	45	0	56.00
57.00	05700	CT SCAN	0	920	0	1,239	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	164	0	30	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	986	336	19	59.00
60.00	06000	LABORATORY	0	1,333	0	30,098	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,243	0	1,362	0	65.00
66.00	06600	PHYSICAL THERAPY	0	374	2,667	139	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	255	1,815	77	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	134	948	31	0	68.00
68.01	03040	AUDIOLOGY	0	34	0	49	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	545	0	139	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,101	822	144	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	198,604	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	414,570	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,513	0	90.00
91.00	09100	EMERGENCY	0	3,161	8,700	4,618	47	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	62	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,197	35,695	48,618	262,683	415,723	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	512	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	134,197	36,207	48,618	262,683	415,723	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	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
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	131,889				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	4,494		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,335	0	887,682	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,196	0	230,542	0	31.00
41.00	04100	SUBPROVIDER - IRF	1,691	0	217,956	0	41.00
43.00	04300	NURSERY	805	0	74,782	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,729	0	970,430	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,076	0	432,579	0	52.00
53.00	05300	ANESTHESIOLOGY	2,725	0	13,555	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,368	0	765,145	0	54.00
56.00	05600	RADIOISOTOPE	889	0	26,908	0	56.00
57.00	05700	CT SCAN	14,217	0	564,410	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,528	0	300,582	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,322	0	464,623	0	59.00
60.00	06000	LABORATORY	16,619	0	452,984	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,428	0	179,265	0	65.00
66.00	06600	PHYSICAL THERAPY	2,571	0	220,119	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,764	0	359,885	0	67.00
68.00	06800	SPEECH PATHOLOGY	675	0	141,518	0	68.00
68.01	03040	AUDIOLOGY	227	0	11,161	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,692	0	89,542	0	69.00
69.01	03160	CARDIOPULMONARY	371	0	83,601	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	488	0	7,358	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,930	0	358,541	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,975	0	461,837	0	73.00
74.00	07400	RENAL DIALYSIS	47	0	4,171	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,433	0	1,229,938	0	90.00
91.00	09100	EMERGENCY	16,479	0	505,838	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	309	0	44,211	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,889	0	9,099,163	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	23,993	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	515,918	0	192.00
193.00	19300	NONPAID WORKERS	0	0	344,295	0	193.00
200.00		Cross Foot Adjustments			4,494	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	131,889	0	4,494	9,987,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/27/2020 3:17 pm

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
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
23.00	02300	PARAMEDICAL EDUCATION PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	03040	AUDIOLOGY	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 3:17 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	450,608					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		3,312,083				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1,248	25,066	56,721,192			4.00
5.00 00500 ADMINISTRATIVE & GENERAL	36,148	1,029,497	8,824,373	-24,779,122	108,939,951	5.00
6.00 00600 MAINTENANCE & REPAIRS	2,895	120,503	1,038,060	0	2,299,601	6.00
7.00 00700 OPERATION OF PLANT	36,124	262,960	181,963	0	2,869,265	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	428	0	62,687	0	596,787	8.00
9.00 00900 HOUSEKEEPING	2,964	11,941	1,332,789	0	1,953,925	9.00
10.00 01000 DIETARY	10,480	5,251	266,855	0	746,041	10.00
11.00 01100 CAFETERIA	0	12,712	646,187	0	1,532,329	11.00
13.00 01300 NURSING ADMINISTRATION	2,776	0	734,711	0	919,331	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	10,580	48,942	779,870	0	1,227,542	14.00
15.00 01500 PHARMACY	2,468	46,795	0	0	5,933,357	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	8,830	1,796	1,117,008	0	1,870,921	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
23.00 02300 PARAMEDICAL EDUCATION PRGM	0	0	172,023	0	214,973	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	39,441	81,719	9,043,047	0	12,239,397	30.00
31.00 03100 INTENSIVE CARE UNIT	9,203	46,695	2,174,660	0	3,166,880	31.00
41.00 04100 SUBPROVIDER - IRF	7,085	60,949	1,372,890	0	2,635,921	41.00
43.00 04300 NURSERY	1,022	30,725	1,179,993	0	1,630,013	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	31,405	301,466	5,313,834	0	9,356,895	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	30,823	41,067	1,577,149	0	2,339,582	52.00
53.00 05300 ANESTHESIOLOGY	0	5,988	0	0	212,003	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,228	241,180	2,267,776	0	4,349,618	54.00
56.00 05600 RADIOISOTOPE	1,088	8,208	163,047	0	327,353	56.00
57.00 05700 CT SCAN	14,500	226,151	416,810	0	1,326,772	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3,015	22,204	170,033	0	649,402	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	193,993	803,572	0	1,665,258	59.00
60.00 06000 LABORATORY	9,142	191,613	1,662,271	0	5,815,834	60.00
65.00 06500 RESPIRATORY THERAPY	6,010	39,988	1,164,863	0	1,791,317	65.00
66.00 06600 PHYSICAL THERAPY	14,685	12,622	1,512,815	0	2,247,555	66.00
67.00 06700 OCCUPATIONAL THERAPY	29,405	2,820	941,954	0	1,567,732	67.00
68.00 06800 SPEECH PATHOLOGY	11,025	718	773,527	0	1,041,754	68.00
68.01 03040 AUDIOLOGY	461	2,264	319,278	0	211,571	68.01
69.00 06900 ELECTROCARDIOLOGY	0	43,413	528,392	0	912,599	69.00
69.01 03160 CARDIOPULMONARY	4,843	14,584	536,179	0	755,860	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	5,179	70,646	0	95,335	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,564,843	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1,866,210	0	2,321,565	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	281,067	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	10,819	163,865	861,356	0	10,979,941	90.00
91.00 09100 EMERGENCY	29,389	9,209	5,701,639	0	8,058,956	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1,848	0	1,142,725	0	1,530,378	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	372,378	3,312,083	56,721,192	-24,779,122	108,239,473	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,124	0	0	0	19,019	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	45,627	0	0	0	408,546	192.00
193.00 19300 NONPAID WORKERS	30,479	0	0	0	272,913	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4,034,798	3,465,150	13,839,992		24,779,122	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	8.954120	1.046215	0.244000		0.227457	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			37,399		1,598,359	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000659		0.014672	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	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	410,317					6.00
7.00	00700	OPERATION OF PLANT	36,124	374,193				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	428	1,238,625			8.00
9.00	00900	HOUSEKEEPING	2,964	2,964	0	10,381		9.00
10.00	01000	DIETARY	10,480	10,480	0	0	94,518	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,776	2,776	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,580	10,580	17,672	64	0	14.00
15.00	01500	PHARMACY	2,468	2,468	0	124	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,830	8,830	0	119	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,441	39,441	436,477	3,563	71,013	30.00
31.00	03100	INTENSIVE CARE UNIT	9,203	9,203	66,864	1,375	7,640	31.00
41.00	04100	SUBPROVIDER - IRF	7,085	7,085	0	940	15,865	41.00
43.00	04300	NURSERY	1,022	1,022	0	356	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,405	31,405	181,174	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,823	30,823	126,025	476	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,228	2,228	34,586	302	0	54.00
56.00	05600	RADIOISOTOPE	1,088	1,088	3,680	32	0	56.00
57.00	05700	CT SCAN	14,500	14,500	58,759	513	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,015	3,015	10,454	91	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	14,237	0	0	59.00
60.00	06000	LABORATORY	9,142	9,142	0	188	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,010	6,010	0	187	0	65.00
66.00	06600	PHYSICAL THERAPY	14,685	14,685	7,173	436	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,405	29,405	89,204	17	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,025	11,025	2,555	9	0	68.00
68.01	03040	AUDIOLOGY	461	461	652	2	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	8,129	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,843	4,843	0	54	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,819	10,819	0	0	0	90.00
91.00	09100	EMERGENCY	29,389	29,389	180,984	1,533	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,848	1,848	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)	332,087	295,963	1,238,625	10,381	94,518	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,124	2,124	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,627	45,627	0	0	0	192.00
193.00	19300	NONPAID WORKERS	30,479	30,479	0	0	0	193.00
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)	2,822,661	3,770,404	739,787	2,448,615	1,093,424	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.879220	10.076094	0.597265	235.874675	11.568421	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	186,418	657,202	13,575	75,132	134,197	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.454327	1.756318	0.010960	7.237453	1.419804	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: 14-0289

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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	49,355				11.00
13.00	01300	NURSING ADMINISTRATION	4,978	13,071			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,105	0	13,973,505		14.00
15.00	01500	PHARMACY	1,509	0	16,719	3,492,322	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,240	0	66	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	1,672	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,061	4,171	338,517	6,986	30.00
31.00	03100	INTENSIVE CARE UNIT	3,064	775	163,349	956	31.00
41.00	04100	SUBPROVIDER - IRF	2,232	594	23,237	349	41.00
43.00	04300	NURSERY	844	452	44,448	127	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,579	2,189	517,208	539	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,128	605	59,426	170	52.00
53.00	05300	ANESTHESIOLOGY	800	0	46,098	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738	0	24,519	0	54.00
56.00	05600	RADIOISOTOPE	79	0	2,377	0	56.00
57.00	05700	CT SCAN	1,254	0	65,934	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	223	0	1,606	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	265	17,884	160	59.00
60.00	06000	LABORATORY	1,817	0	1,601,063	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,695	0	72,437	0	65.00
66.00	06600	PHYSICAL THERAPY	510	717	7,378	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	348	488	4,120	0	67.00
68.00	06800	SPEECH PATHOLOGY	182	255	1,640	0	68.00
68.01	03040	AUDIOLOGY	46	0	2,600	0	68.01
69.00	06900	ELECTROCARDIOLOGY	743	0	7,386	0	69.00
69.01	03160	CARDIOPULMONARY	1,501	221	7,684	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	338	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10,564,843	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,482,637	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	19	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	133,656	0	90.00
91.00	09100	EMERGENCY	4,309	2,339	245,664	398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	3,308	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,657	13,071	13,973,505	3,492,322	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	698	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,880,868	1,365,213	1,792,012	7,413,685	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.108966	104.445949	0.128244	2.122853	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,207	48,618	262,683	415,723	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.733603	3.719532	0.018799	0.119039	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: 14-0289

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)	
		17.00	23.00	
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
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	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
68.01	03040	AUDIOLOGY	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	03160	CARDIOPULMONARY	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
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)	327,588	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,275.880000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,494	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	44.940000	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: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 3:17 pm

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,830,824	18,830,824	0	18,830,824 30.00
31.00	03100	INTENSIVE CARE UNIT	4,740,137	4,740,137	0	4,740,137 31.00
41.00	04100	SUBPROVIDER - IRF	3,945,000	3,945,000	0	3,945,000 41.00
43.00	04300	NURSERY	2,203,263	2,203,263	0	2,203,263 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,791,958	12,791,958	0	12,791,958 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,717,250	3,717,250	0	3,717,250 52.00
53.00	05300	ANESTHESIOLOGY	350,302	350,302	72,679	422,981 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,664,717	5,664,717	63,527	5,728,244 54.00
56.00	05600	RADIOISOTOPE	450,838	450,838	0	450,838 56.00
57.00	05700	CT SCAN	2,366,771	2,366,771	0	2,366,771 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	934,448	934,448	0	934,448 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,128,577	2,128,577	10,429	2,139,006 59.00
60.00	06000	LABORATORY	7,939,974	7,939,974	0	7,939,974 60.00
65.00	06500	RESPIRATORY THERAPY	2,486,175	2,486,175	0	2,486,175 65.00
66.00	06600	PHYSICAL THERAPY	3,260,796	3,260,796	0	3,260,796 66.00
67.00	06700	OCCUPATIONAL THERAPY	2,579,682	2,579,682	0	2,579,682 67.00
68.00	06800	SPEECH PATHOLOGY	1,516,366	1,516,366	0	1,516,366 68.00
68.01	03040	AUDIOLOGY	274,922	274,922	0	274,922 68.01
69.00	06900	ELECTROCARDIOLOGY	1,227,009	1,227,009	0	1,227,009 69.00
69.01	03160	CARDIOPULMONARY	1,111,219	1,111,219	0	1,111,219 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	126,680	126,680	0	126,680 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,419,863	14,419,863	0	14,419,863 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,478,605	10,478,605	0	10,478,605 73.00
74.00	07400	RENAL DIALYSIS	345,930	345,930	0	345,930 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,745,598	13,745,598	0	13,745,598 90.00
91.00	09100	EMERGENCY	11,953,031	11,953,031	0	11,953,031 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,029,769	4,029,769	0	4,029,769 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,916,315	1,916,315	0	1,916,315 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	135,536,019	135,536,019	146,635	135,682,654 200.00
201.00		Less Observation Beds	4,029,769	4,029,769		4,029,769 201.00
202.00		Total (see instructions)	131,506,250	131,506,250	146,635	131,652,885 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 3:17 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	41,550,576		41,550,576			30.00	
31.00	03100	INTENSIVE CARE UNIT	5,768,435		5,768,435			31.00	
41.00	04100	SUBPROVIDER - IRF	8,158,640		8,158,640			41.00	
43.00	04300	NURSERY	3,883,780		3,883,780			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,431,885	58,463,317	75,895,202	0.168548	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,143,541	47,421	5,190,962	0.716100	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,669,746	10,478,905	13,148,651	0.026642	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,080,947	34,298,811	40,379,758	0.140286	0.000000	54.00	
56.00	05600	RADIOISOTOPE	545,825	3,750,257	4,296,082	0.104942	0.000000	56.00	
57.00	05700	CT SCAN	6,302,780	62,299,729	68,602,509	0.034500	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,691,999	10,513,834	12,205,833	0.076557	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	6,071,690	5,127,828	11,199,518	0.190060	0.000000	59.00	
60.00	06000	LABORATORY	25,655,520	54,540,235	80,195,755	0.099007	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	10,555,216	5,985,207	16,540,423	0.150309	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	6,175,283	6,227,313	12,402,596	0.262912	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	5,117,198	3,391,011	8,508,209	0.303199	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	1,129,518	2,130,895	3,260,413	0.465084	0.000000	68.00	
68.01	03040	AUDIOLOGY	0	1,099,287	1,099,287	0.250091	0.000000	68.01	
69.00	06900	ELECTROCARDIOLOGY	5,046,328	12,763,953	17,810,281	0.068893	0.000000	69.00	
69.01	03160	CARDIOPULMONARY	961	1,795,582	1,796,543	0.618532	0.000000	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	85,276	2,269,470	2,354,746	0.053798	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,843,887	13,943,495	23,787,382	0.606198	0.000000	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	14,198,014	43,585,645	57,783,659	0.181342	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	911,773	131,162	1,042,935	0.331689	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	36,929	16,525,808	16,562,737	0.829911	0.000000	90.00	
91.00	09100	EMERGENCY	13,305,604	66,204,784	79,510,388	0.150333	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,696,631	14,272,145	21,968,776	0.183432	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1,490,148	1,490,148			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	205,057,982	431,336,242	636,394,224			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	205,057,982	431,336,242	636,394,224			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.168548			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.716100			52.00
53.00	05300	ANESTHESIOLOGY	0.032169			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141859			54.00
56.00	05600	RADIOISOTOPE	0.104942			56.00
57.00	05700	CT SCAN	0.034500			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.076557			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.190991			59.00
60.00	06000	LABORATORY	0.099007			60.00
65.00	06500	RESPIRATORY THERAPY	0.150309			65.00
66.00	06600	PHYSICAL THERAPY	0.262912			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.303199			67.00
68.00	06800	SPEECH PATHOLOGY	0.465084			68.00
68.01	03040	AUDIOLOGY	0.250091			68.01
69.00	06900	ELECTROCARDIOLOGY	0.068893			69.00
69.01	03160	CARDIOPULMONARY	0.618532			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053798			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.606198			71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181342			73.00
74.00	07400	RENAL DIALYSIS	0.331689			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.829911			90.00
91.00	09100	EMERGENCY	0.150333			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.183432			92.00
OTHER REIMBURSABLE COST CENTERS						
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: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/27/2020 3:17 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	887,682	0	887,682	25,818	34.38	30.00
31.00	INTENSIVE CARE UNIT	230,542		230,542	2,238	103.01	31.00
41.00	SUBPROVIDER - IRF	217,956	0	217,956	4,647	46.90	41.00
43.00	NURSERY	74,782		74,782	2,907	25.72	43.00
200.00	Total (lines 30 through 199)	1,410,962		1,410,962	35,610		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	8,287	284,907				
31.00	INTENSIVE CARE UNIT	847	87,249				
41.00	SUBPROVIDER - IRF	2,761	129,491				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	11,895	501,647				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. C, 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	970,430	75,895,202	0.012786	5,264,636	67,314
52.00	05200	DELIVERY ROOM & LABOR ROOM	432,579	5,190,962	0.083333	11,973	998
53.00	05300	ANESTHESIOLOGY	13,555	13,148,651	0.001031	834,933	861
54.00	05400	RADIOLOGY-DIAGNOSTIC	765,145	40,379,758	0.018949	3,718,012	70,453
56.00	05600	RADIOISOTOPE	26,908	4,296,082	0.006263	326,995	2,048
57.00	05700	CT SCAN	564,410	68,602,509	0.008227	6,135,221	50,474
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	300,582	12,205,833	0.024626	805,569	19,838
59.00	05900	CARDIAC CATHETERIZATION	464,623	11,199,518	0.041486	2,263,369	93,898
60.00	06000	LABORATORY	452,984	80,195,755	0.005648	12,575,748	71,028
65.00	06500	RESPIRATORY THERAPY	179,265	16,540,423	0.010838	5,416,982	58,709
66.00	06600	PHYSICAL THERAPY	220,119	12,402,596	0.017748	1,549,827	27,506
67.00	06700	OCCUPATIONAL THERAPY	359,885	8,508,209	0.042299	1,040,496	44,012
68.00	06800	SPEECH PATHOLOGY	141,518	3,260,413	0.043405	257,359	11,171
68.01	03040	AUDIOLOGY	11,161	1,099,287	0.010153	0	0
69.00	06900	ELECTROCARDIOLOGY	89,542	17,810,281	0.005028	3,103,892	15,606
69.01	03160	CARDIOPULMONARY	83,601	1,796,543	0.046534	961	45
70.00	07000	ELECTROENCEPHALOGRAPHY	7,358	2,354,746	0.003125	46,656	146
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	358,541	23,787,382	0.015073	4,288,013	64,633
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	461,837	57,783,659	0.007993	5,953,715	47,588
74.00	07400	RENAL DIALYSIS	4,171	1,042,935	0.003999	556,603	2,226
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,229,938	16,562,737	0.074259	3,335	248
91.00	09100	EMERGENCY	505,838	79,510,388	0.006362	6,563,641	41,758
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	189,963	21,968,776	0.008647	2,899,383	25,071
200.00		Total (lines 50 through 199)	7,833,953	575,542,645		63,617,319	715,631

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0289		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/27/2020 3:17 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	25,818	0.00	8,287	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	2,238	0.00	847	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	4,647	0.00	2,761	41.00		
43.00	04300	NURSERY	0	0	2,907	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	35,610		11,895	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
31.00	03100	INTENSIVE CARE UNIT	0							31.00
41.00	04100	SUBPROVIDER - IRF	0							41.00
43.00	04300	NURSERY	0							43.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	327,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	327,588	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 3:17 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	75,895,202	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,190,962	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,148,651	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,379,758	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,296,082	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	68,602,509	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,205,833	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,199,518	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	80,195,755	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	16,540,423	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,402,596	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,508,209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,260,413	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	1,099,287	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,810,281	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,796,543	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,354,746	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	23,787,382	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,783,659	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,042,935	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,562,737	0.000000	90.00
91.00	09100	EMERGENCY	0	327,588	327,588	79,510,388	0.004120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	21,968,776	0.000000	92.00
200.00		Total (lines 50 through 199)	0	327,588	327,588	575,542,645		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description			Title XVIII			Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	5,264,636	0	12,138,474	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	11,973	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	834,933	0	2,082,168	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,718,012	0	5,196,655	0	54.00	
56.00	05600	RADIOISOTOPE	0.000000	326,995	0	1,054,018	0	56.00	
57.00	05700	CT SCAN	0.000000	6,135,221	0	13,812,692	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	805,569	0	2,466,694	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,263,369	0	1,577,594	0	59.00	
60.00	06000	LABORATORY	0.000000	12,575,748	0	6,950,204	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	5,416,982	0	1,430,476	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	1,549,827	0	111,599	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,040,496	0	57,388	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	257,359	0	13,411	0	68.00	
68.01	03040	AUDIOLOGY	0.000000	0	0	127,808	0	68.01	
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,103,892	0	3,075,953	0	69.00	
69.01	03160	CARDIOPULMONARY	0.000000	961	0	759,892	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	46,656	0	421,075	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,288,013	0	3,703,908	0	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,953,715	0	15,360,247	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	556,603	0	26,586	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	3,335	0	6,212,681	0	90.00	
91.00	09100	EMERGENCY	0.004120	6,563,641	27,042	9,745,907	40,153	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,899,383	0	3,014,020	0	92.00	
200.00		Total (lines 50 through 199)		63,617,319	27,042	89,339,450	40,153	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 3:17 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	0.168548	12,138,474	0	0	2,045,916	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.716100	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026642	2,082,168	0	0	55,473	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140286	5,196,655	0	0	729,018	54.00
56.00	05600	RADIOISOTOPE	0.104942	1,054,018	0	0	110,611	56.00
57.00	05700	CT SCAN	0.034500	13,812,692	0	0	476,538	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.076557	2,466,694	0	0	188,843	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.190060	1,577,594	0	0	299,838	59.00
60.00	06000	LABORATORY	0.099007	6,950,204	0	0	688,119	60.00
65.00	06500	RESPIRATORY THERAPY	0.150309	1,430,476	0	0	215,013	65.00
66.00	06600	PHYSICAL THERAPY	0.262912	111,599	0	0	29,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.303199	57,388	0	0	17,400	67.00
68.00	06800	SPEECH PATHOLOGY	0.465084	13,411	0	0	6,237	68.00
68.01	03040	AUDIOLOGY	0.250091	127,808	0	0	31,964	68.01
69.00	06900	ELECTROCARDIOLOGY	0.068893	3,075,953	0	0	211,912	69.00
69.01	03160	CARDIOPULMONARY	0.618532	759,892	0	0	470,018	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053798	421,075	0	0	22,653	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.606198	3,703,908	0	0	2,245,302	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181342	15,360,247	0	18,437	2,785,458	73.00
74.00	07400	RENAL DIALYSIS	0.331689	26,586	0	0	8,818	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.829911	6,212,681	0	0	5,155,972	90.00
91.00	09100	EMERGENCY	0.150333	9,745,907	0	111	1,465,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.183432	3,014,020	0	0	552,868	92.00
200.00		Subtotal (see instructions)		89,339,450	0	18,548	17,812,443	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		89,339,450	0	18,548	17,812,443	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 3:17 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	03040	AUDIOLOGY	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,343		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	17		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	3,360		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,360		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/27/2020 3:17 pm		
				Component CCN:14-T289				
				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	970,430	75,895,202	0.012786	9,192	118	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	432,579	5,190,962	0.083333	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,555	13,148,651	0.001031	2,446	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	765,145	40,379,758	0.018949	169,158	3,205	54.00
56.00	05600	RADIOISOTOPE	26,908	4,296,082	0.006263	3,132	20	56.00
57.00	05700	CT SCAN	564,410	68,602,509	0.008227	119,830	986	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	300,582	12,205,833	0.024626	35,266	868	58.00
59.00	05900	CARDIAC CATHETERIZATION	464,623	11,199,518	0.041486	60	2	59.00
60.00	06000	LABORATORY	452,984	80,195,755	0.005648	544,494	3,075	60.00
65.00	06500	RESPIRATORY THERAPY	179,265	16,540,423	0.010838	226,252	2,452	65.00
66.00	06600	PHYSICAL THERAPY	220,119	12,402,596	0.017748	1,951,850	34,641	66.00
67.00	06700	OCCUPATIONAL THERAPY	359,885	8,508,209	0.042299	1,915,829	81,038	67.00
68.00	06800	SPEECH PATHOLOGY	141,518	3,260,413	0.043405	369,855	16,054	68.00
68.01	03040	AUDIOLOGY	11,161	1,099,287	0.010153	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	89,542	17,810,281	0.005028	26,219	132	69.00
69.01	03160	CARDIOPULMONARY	83,601	1,796,543	0.046534	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	7,358	2,354,746	0.003125	1,866	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	358,541	23,787,382	0.015073	84,092	1,268	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	461,837	57,783,659	0.007993	566,679	4,529	73.00
74.00	07400	RENAL DIALYSIS	4,171	1,042,935	0.003999	97,475	390	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,229,938	16,562,737	0.074259	0	0	90.00
91.00	09100	EMERGENCY	505,838	79,510,388	0.006362	37,949	241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	21,968,776	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	7,643,990	575,542,645		6,161,644	149,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 3:17 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY		0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	327,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	327,588	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0289 Component CCN:14-T289		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 3:17 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) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	75,895,202	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	5,190,962	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,148,651	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	40,379,758	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	4,296,082	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	68,602,509	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	12,205,833	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	11,199,518	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	80,195,755	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	16,540,423	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	12,402,596	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	8,508,209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	3,260,413	0.000000	68.00
68.01	03040	AUDIOLOGY		0	0	0	1,099,287	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	17,810,281	0.000000	69.00
69.01	03160	CARDIOPULMONARY		0	0	0	1,796,543	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	2,354,746	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	23,787,382	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	57,783,659	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,042,935	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	16,562,737	0.000000	90.00
91.00	09100	EMERGENCY		0	327,588	327,588	79,510,388	0.004120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	21,968,776	0.000000	92.00
200.00		Total (lines 50 through 199)		0	327,588	327,588	575,542,645		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN:14-0289

Component CCN:14-T289

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

Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 3:17 pm

				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	9,192	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	2,446	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	169,158	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	3,132	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	119,830	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	35,266	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	60	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	544,494	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	226,252	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,951,850	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,915,829	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	369,855	0	0	0	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	26,219	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,866	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	84,092	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	566,679	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	97,475	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.004120	37,949	156	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		6,161,644	156	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 3:17 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)			25,818	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			25,818	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)			20,293	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			8,287	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)			18,830,824	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)			18,830,824	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)			18,830,824	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)			729.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,044,289	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)			6,044,289	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0289

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 3:17 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	4,740,137	2,238	2,118.02	847	1,793,963	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					10,694,036	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					18,532,288	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)					372,156	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					742,673	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,114,829	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,417,459	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)					5,525	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					729.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,029,769	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0289		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/27/2020 3:17 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
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	887,682	18,830,824	0.047140	4,029,769	189,963		90.00	
91.00	Nursing School cost	0	18,830,824	0.000000	4,029,769	0		91.00	
92.00	Allied health cost	0	18,830,824	0.000000	4,029,769	0		92.00	
93.00	All other Medical Education	0	18,830,824	0.000000	4,029,769	0		93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 3:17 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)		4,647	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,647	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,647	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,761	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,945,000	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,945,000	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,945,000	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)		848.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,343,896	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)		2,343,896	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1	
				Component CCN: 14-T289		Date/Time Prepared: 8/27/2020 3:17 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	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,580,453	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,924,349	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)					129,491	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					149,184	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					278,675	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,645,674	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: 14-0289 Component CCN: 14-T289		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/27/2020 3:17 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	217,956	3,945,000	0.055249	0	0	90.00
91.00	Nursing School cost	0	3,945,000	0.000000	0	0	91.00
92.00	Allied health cost	0	3,945,000	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,945,000	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 3:17 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		13,139,912		30.00
31.00	03100	INTENSIVE CARE UNIT		2,246,387		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.168548	5,264,636	887,344	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.716100	11,973	8,574	52.00
53.00	05300	ANESTHESIOLOGY	0.032169	834,933	26,859	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141859	3,718,012	527,433	54.00
56.00	05600	RADIOISOTOPE	0.104942	326,995	34,316	56.00
57.00	05700	CT SCAN	0.034500	6,135,221	211,665	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.076557	805,569	61,672	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.190991	2,263,369	432,283	59.00
60.00	06000	LABORATORY	0.099007	12,575,748	1,245,087	60.00
65.00	06500	RESPIRATORY THERAPY	0.150309	5,416,982	814,221	65.00
66.00	06600	PHYSICAL THERAPY	0.262912	1,549,827	407,468	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.303199	1,040,496	315,477	67.00
68.00	06800	SPEECH PATHOLOGY	0.465084	257,359	119,694	68.00
68.01	03040	AUDIOLOGY	0.250091	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.068893	3,103,892	213,836	69.00
69.01	03160	CARDIOPULMONARY	0.618532	961	594	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053798	46,656	2,510	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.606198	4,288,013	2,599,385	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181342	5,953,715	1,079,659	73.00
74.00	07400	RENAL DIALYSIS	0.331689	556,603	184,619	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.829911	3,335	2,768	90.00
91.00	09100	EMERGENCY	0.150333	6,563,641	986,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.183432	2,899,383	531,840	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		63,617,319	10,694,036	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)		63,617,319		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 3:17 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
41.00	04100 SUBPROVIDER - IRF		4,961,166		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.168548	9,192	1,549	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.716100	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.032169	2,446	79	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.141859	169,158	23,997	54.00
56.00	05600 RADIOISOTOPE	0.104942	3,132	329	56.00
57.00	05700 CT SCAN	0.034500	119,830	4,134	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.076557	35,266	2,700	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.190991	60	11	59.00
60.00	06000 LABORATORY	0.099007	544,494	53,909	60.00
65.00	06500 RESPIRATORY THERAPY	0.150309	226,252	34,008	65.00
66.00	06600 PHYSICAL THERAPY	0.262912	1,951,850	513,165	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.303199	1,915,829	580,877	67.00
68.00	06800 SPEECH PATHOLOGY	0.465084	369,855	172,014	68.00
68.01	03040 AUDIOLOGY	0.250091	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.068893	26,219	1,806	69.00
69.01	03160 CARDIOPULMONARY	0.618532	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.053798	1,866	100	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.606198	84,092	50,976	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181342	566,679	102,763	73.00
74.00	07400 RENAL DIALYSIS	0.331689	97,475	32,331	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.829911	0	0	90.00
91.00	09100 EMERGENCY	0.150333	37,949	5,705	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.183432	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,161,644	1,580,453	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)		6,161,644		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 3:17 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)		17,135,769	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)		103,061	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)		114.86	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)		2.74	30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.97	31.00
32.00	Sum of lines 30 and 31		19.71	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.56	33.00
34.00	Disproportionate share adjustment (see instructions)		238,187	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 3:17 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,028,405	1,046,943	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	769,190	263,166	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,032,356		
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)	18,509,373		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		18,509,373	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,438,655	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	
53.00	Nursing and Allied Health Managed Care payment		32,062	
54.00	Special add-on payments for new technologies		0	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		27,042	
59.00	Total (sum of amounts on lines 49 through 58)		20,007,132	
60.00	Primary payer payments		29,332	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		19,977,800	
62.00	Deductibles billed to program beneficiaries		2,141,048	
63.00	Coinurance billed to program beneficiaries		24,893	
64.00	Allowable bad debts (see instructions)		366,320	
65.00	Adjusted reimbursable bad debts (see instructions)		238,108	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		330,217	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		18,049,967	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		52,705	
70.94	HRR adjustment amount (see instructions)		-31,827	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 3:17 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)		18,070,845	71.00	
71.01	Sequestration adjustment (see instructions)		361,417	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		17,781,309	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-71,881	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		434,764	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: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/27/2020 3:17 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	17,135,769	0		17,135,769	17,135,769
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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
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	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	103,061	0		103,061	103,061
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	
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	
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	0.0556	0.0556	0.0556	0.0556	
11.00	Disproportionate share adjustment (see instructions)	34.00	238,187	0	0	238,187	238,187
11.01	Uncompensated care payments	36.00	1,032,356	0	769,190	263,166	1,032,356
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	18,509,373	0	769,190	17,740,183	18,509,373
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	18,509,373	0	769,190	17,740,183	18,509,373

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/27/2020 3:17 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
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,438,655	0	0	1,438,655	1,438,655
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	769,190	19,178,838	19,948,028
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,378,366	0	0	1,378,366	1,378,366
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	4,190	0	0	4,190	4,190
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.00000	0.00000	0.00000	0.00000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0407	0.0407	0.0407	0.0407	
25.00	Disproportionate share adjustment (see instructions)	11.00	56,099	0	0	56,099	56,099
26.00	Total prospective capital payments (see instructions)	12.00	1,438,655	0	0	1,438,655	1,438,655
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/27/2020 3:17 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	17,135,769		17,135,769	17,135,769	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	103,061		103,061	103,061	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	0.0556	0.0556	0.0556		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	238,187	0	238,187	238,187	11.00
11.01	Uncompensated care payments	36.00	1,032,356	769,190	263,166	1,032,356	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	18,509,373	769,190	17,740,183	18,509,373	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	18,509,373	769,190	17,740,183	18,509,373	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,438,655	0	1,438,655	1,438,655	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			769,190	19,178,838	19,948,028	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/27/2020 3:17 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,378,366	0	1,378,366	1,378,366	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	4,190	0	4,190	4,190	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	0.0407	0.0407	0.0407		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	56,099	0	56,099	56,099	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,438,655	0	1,438,655	1,438,655	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	52,705	0	52,705	52,705	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	-31,827	0	-31,827	-31,827	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/27/2020 3:17 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,360	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,772,290	2.00
3.00	OPPS payments		15,329,333	3.00
4.00	Outlier payment (see instructions)		8,733	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		40,153	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,360	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		18,548	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)		18,548	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)		18,548	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		15,188	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		3,360	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)		15,378,219	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)		2,838,150	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)		12,543,429	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)		12,543,429	30.00
31.00	Primary payer payments		12,657	31.00
32.00	Subtotal (line 30 minus line 31)		12,530,772	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)		244,412	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		158,868	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		164,334	36.00
37.00	Subtotal (see instructions)		12,689,640	37.00
38.00	MSP-LCC reconciliation amount from PS&R		40	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		12,689,600	40.00
40.01	Sequestration adjustment (see instructions)		253,792	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		12,457,675	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-21,867	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/27/2020 3:17 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		17,781,309		12,457,675	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,781,309		12,457,675	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		71,881		21,867	6.02	
7.00	Total Medicare program liability (see instructions)		17,709,428		12,435,808	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: 14-0289

Period:

Worksheet E-1

Component CCN: 14-T289

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/27/2020 3:17 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		4,612,439		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,612,439		0	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		19,639		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,632,078		0	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: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/27/2020 3:17 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: 14-0289 Component CCN: 14-T289	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part III Date/Time Prepared: 8/27/2020 3:17 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4,605,377 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0304 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			172,702 3.00
4.00	Outlier Payments			13,186 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)			12.731507 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)			4,791,265 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,791,265 17.00
18.00	Primary payer payments			6,759 18.00
19.00	Subtotal (line 17 less line 18).			4,784,506 19.00
20.00	Deductibles			64,036 20.00
21.00	Subtotal (line 19 minus line 20)			4,720,470 21.00
22.00	Coinsurance			1,023 22.00
23.00	Subtotal (line 21 minus line 22)			4,719,447 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			10,780 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			7,007 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,100 26.00
27.00	Subtotal (sum of lines 23 and 25)			4,726,454 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)			156 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)			4,726,610 32.00
32.01	Sequestration adjustment (see instructions)			94,532 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			4,612,439 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)			19,639 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			13,186 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0289

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

Worksheet G

Date/Time Prepared:
8/27/2020 3:17 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	5,014,051	0	0	0	1.00
2.00	Temporary investments	86,333,536	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	108,323,722	0	0	0	4.00
5.00	Other receivable	619,548	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-84,887,973	0	0	0	6.00
7.00	Inventory	2,886,626	0	0	0	7.00
8.00	Prepaid expenses	1,338,267	0	0	0	8.00
9.00	Other current assets	7,500	0	0	0	9.00
10.00	Due from other funds	211,941	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	119,847,218	0	0	0	11.00
FIXED ASSETS						
12.00	Land	963,454	0	0	0	12.00
13.00	Land improvements	3,152,271	0	0	0	13.00
14.00	Accumulated depreciation	-2,586,130	0	0	0	14.00
15.00	Buildings	110,871,095	0	0	0	15.00
16.00	Accumulated depreciation	-45,132,394	0	0	0	16.00
17.00	Leasehold improvements	24,000	0	0	0	17.00
18.00	Accumulated depreciation	-24,000	0	0	0	18.00
19.00	Fixed equipment	5,406,514	0	0	0	19.00
20.00	Accumulated depreciation	-4,072,235	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	49,262,191	0	0	0	23.00
24.00	Accumulated depreciation	-26,885,606	0	0	0	24.00
25.00	Minor equipment depreciable	83,185	0	0	0	25.00
26.00	Accumulated depreciation	-83,185	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	7,680	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	90,986,840	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	47,462,730	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	47,462,730	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	258,296,788	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,007,994	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,963,429	0	0	0	38.00
39.00	Payroll taxes payable	117,998	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,008,292	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	665,113	0	0	0	43.00
44.00	Other current liabilities	9,074,919	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,837,745	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	40,732,189	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,983,225	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	63,715,414	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	88,553,159	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	169,743,629	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	169,743,629	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	258,296,788	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0289

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

Worksheet G-1

Date/Time Prepared:
8/27/2020 3:17 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		153,975,503		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		33,253,341				2.00
3.00	Total (sum of line 1 and line 2)		187,228,844		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		187,228,844		0		11.00
12.00	TRANSFERS	17,485,215		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		17,485,215		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		169,743,629		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFERS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0289

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/27/2020 3:17 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	45,434,356		45,434,356	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,158,640		8,158,640	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)	53,592,996		53,592,996	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,768,435		5,768,435	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,768,435		5,768,435	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	59,361,431		59,361,431	17.00
18.00	Ancillary services	124,657,387	332,843,357	457,500,744	18.00
19.00	Outpatient services	21,039,164	97,002,737	118,041,901	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		1,490,148	1,490,148	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	205,057,982	431,336,242	636,394,224	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		147,546,957		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		147,546,957		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0289

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

Worksheet G-3

Date/Time Prepared:
8/27/2020 3:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	636,394,224	1.00
2.00	Less contractual allowances and discounts on patients' accounts	474,738,173	2.00
3.00	Net patient revenues (line 1 minus line 2)	161,656,051	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	147,546,957	4.00
5.00	Net income from service to patients (line 3 minus line 4)	14,109,094	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	17,612,484	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	62	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	69,871	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	1,818	21.00
22.00	Rental of hospital space	1,013,708	22.00
23.00	Governmental appropriations	0	23.00
24.00	MANAGEMENT FEES	180,000	24.00
24.01	AUDIOLOGY INCOME	56,009	24.01
24.02	MISC INCOME	272,926	24.02
25.00	Total other income (sum of lines 6-24)	19,206,878	25.00
26.00	Total (line 5 plus line 25)	33,315,972	26.00
27.00	LOSS ON DISPOSAL OF INCOME	62,631	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	62,631	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	33,253,341	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0289

Period:

Worksheet H

HHA CCN: 14-7420

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

8/27/2020 3:17 pm

							Home Health Agency I	PPS	
		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased 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	0	0	0	3.00	
4.00	Transportation	0	0	0	0	0	0	4.00	
5.00	Administrative and General	195,948	0	0	1,014	23,359	220,321	5.00	
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	511,835	0	20,941	0	0	532,776	6.00	
7.00	Physical Therapy	241,563	0	17,169	16,815	0	275,547	7.00	
8.00	Occupational Therapy	130,225	0	7,810	0	0	138,035	8.00	
9.00	Speech Pathology	3,327	0	1,791	0	0	5,118	9.00	
10.00	Medical Social Services	18,281	0	30	0	0	18,311	10.00	
11.00	Home Health Aide	41,546	0	3,287	0	0	44,833	11.00	
12.00	Supplies (see instructions)	0	0	0	0	16,356	16,356	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)	1,142,725	0	51,028	17,829	39,715	1,251,297	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	0	0	0			3.00	
4.00	Transportation	0	0	0	0			4.00	
5.00	Administrative and General	-3,242	217,079	0	217,079			5.00	
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	0	532,776	0	532,776			6.00	
7.00	Physical Therapy	0	275,547	0	275,547			7.00	
8.00	Occupational Therapy	0	138,035	0	138,035			8.00	
9.00	Speech Pathology	0	5,118	0	5,118			9.00	
10.00	Medical Social Services	0	18,311	0	18,311			10.00	
11.00	Home Health Aide	0	44,833	0	44,833			11.00	
12.00	Supplies (see instructions)	-13,049	3,307	0	3,307			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)	-16,291	1,235,006	0	1,235,006			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: 14-0289

Period:

Worksheet H-1

HHA CCN: 14-7420

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/27/2020 3:17 pmHome Health
Agency I

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n	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	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	217,079	0	0	0	0	217,079	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	532,776	0	0	0	0	532,776	6.00
7.00	Physical Therapy	275,547	0	0	0	0	275,547	7.00
8.00	Occupational Therapy	138,035	0	0	0	0	138,035	8.00
9.00	Speech Pathology	5,118	0	0	0	0	5,118	9.00
10.00	Medical Social Services	18,311	0	0	0	0	18,311	10.00
11.00	Home Health Aide	44,833	0	0	0	0	44,833	11.00
12.00	Supplies (see instructions)	3,307	0	0	0	0	3,307	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)	1,235,006	0	0	0	0	1,235,006	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	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	217,079						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	113,618	646,394					6.00
7.00	Physical Therapy	58,762	334,309					7.00
8.00	Occupational Therapy	29,437	167,472					8.00
9.00	Speech Pathology	1,091	6,209					9.00
10.00	Medical Social Services	3,905	22,216					10.00
11.00	Home Health Aide	9,561	54,394					11.00
12.00	Supplies (see instructions)	705	4,012					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)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,235,006					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0289

Period:

Worksheet H-1

HHA CCN: 14-7420

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/27/2020 3:17 pmHome Health
Agency I

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		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & 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	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-217,079	1,017,927	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	532,776	6.00
7.00	Physical Therapy	0	0	0	0	0	275,547	7.00
8.00	Occupational Therapy	0	0	0	0	0	138,035	8.00
9.00	Speech Pathology	0	0	0	0	0	5,118	9.00
10.00	Medical Social Services	0	0	0	0	0	18,311	10.00
11.00	Home Health Aide	0	0	0	0	0	44,833	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	3,307	12.00
13.00	Drugs	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)	0	0	0	0	-217,079	1,017,927	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		217,079	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.213256	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/27/2020 3:17 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	16,547	0	47,811	64,358	14,639	1.00
2.00	Skilled Nursing Care	646,394	0	0	124,888	771,282	175,433	2.00
3.00	Physical Therapy	334,309	0	0	58,941	393,250	89,447	3.00
4.00	Occupational Therapy	167,472	0	0	31,775	199,247	45,320	4.00
5.00	Speech Pathology	6,209	0	0	812	7,021	1,597	5.00
6.00	Medical Social Services	22,216	0	0	4,461	26,677	6,068	6.00
7.00	Home Health Aide	54,394	0	0	10,137	64,531	14,678	7.00
8.00	Supplies (see instructions)	4,012	0	0	0	4,012	913	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)	1,235,006	16,547	0	278,825	1,530,378	348,095	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	12,713	18,621	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)	12,713	18,621	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

(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: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2019

Part I

To 12/31/2019

Date/Time Prepared:
8/27/2020 3:17 pmHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	
		13.00	14.00	15.00	16.00	17.00	23.00	
1.00	Administrative and General	0	424	0	6,084	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	424	0	6,084	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		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	116,839	0	116,839				1.00
2.00	Skilled Nursing Care	946,715	0	946,715	61,470	1,008,185		2.00
3.00	Physical Therapy	482,697	0	482,697	31,341	514,038		3.00
4.00	Occupational Therapy	244,567	0	244,567	15,879	260,446		4.00
5.00	Speech Pathology	8,618	0	8,618	560	9,178		5.00
6.00	Medical Social Services	32,745	0	32,745	2,126	34,871		6.00
7.00	Home Health Aide	79,209	0	79,209	5,143	84,352		7.00
8.00	Supplies (see instructions)	4,925	0	4,925	320	5,245		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,916,315	0	1,916,315	116,839	1,916,315		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.				0.064929			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: 14-0289
HHA CCN: 14-7420Period:
From 01/01/2019
To 12/31/2019Worksheet H-2
Part II
Date/Time Prepared:
8/27/2020 3:17 pm

						Home Health Agency I	PPS	
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00					
1.00	Administrative and General	1,848	0	195,948	0	64,358	1,848	1.00
2.00	Skilled Nursing Care	0	0	511,835	0	771,282	0	2.00
3.00	Physical Therapy	0	0	241,563	0	393,250	0	3.00
4.00	Occupational Therapy	0	0	130,225	0	199,247	0	4.00
5.00	Speech Pathology	0	0	3,327	0	7,021	0	5.00
6.00	Medical Social Services	0	0	18,281	0	26,677	0	6.00
7.00	Home Health Aide	0	0	41,546	0	64,531	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	4,012	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)	1,848	0	1,142,725		1,530,378	1,848	20.00
21.00	Total cost to be allocated	16,547	0	278,825		348,095	12,713	21.00
22.00	Unit cost multiplier	8.954004	0.000000	0.244000		0.227457	6.879329	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,848	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)	1,848	0	0	0	0	0	20.00
21.00	Total cost to be allocated	18,621	0	0	0	0	0	21.00
22.00	Unit cost multiplier	10.076299	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/27/2020 3:17 pmHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)		
		14.00	15.00	16.00	17.00	23.00		
1.00	Administrative and General	3,308	0	124	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	3,308	0	124	0	0		20.00
21.00	Total cost to be allocated	424	0	6,084	0	0		21.00
22.00	Unit cost multiplier	0.128174	0.000000	49.064516	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/27/2020 3:17 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	1,008,185		1,008,185	3,542	284.64	1.00
2.00	Physical Therapy	3.00	514,038	0	514,038	2,904	177.01	2.00
3.00	Occupational Therapy	4.00	260,446	0	260,446	1,321	197.16	3.00
4.00	Speech Pathology	5.00	9,178	0	9,178	303	30.29	4.00
5.00	Medical Social Services	6.00	34,871		34,871	5	6,974.20	5.00
6.00	Home Health Aide	7.00	84,352		84,352	556	151.71	6.00
7.00	Total (sum of lines 1-6)		1,911,070	0	1,911,070	8,631		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Program Visits				
				Part A	Part B			
						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		41180	0	1,609			8.00
9.00	Physical Therapy		41180	0	1,190			9.00
10.00	Occupational Therapy		41180	0	528			10.00
11.00	Speech Pathology		41180	0	143			11.00
12.00	Medical Social Services		41180	0	4			12.00
13.00	Home Health Aide		41180	0	227			13.00
14.00	Total (sum of lines 8-13)			0	3,701			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	5,245	0	5,245	0	0.000000	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	Subject to Deductibles & Coinsurance	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
		6.00	7.00	8.00	9.00	10.00	11.00	
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	1,609		0	457,986		1.00
2.00	Physical Therapy	0	1,190		0	210,642		2.00
3.00	Occupational Therapy	0	528		0	104,100		3.00
4.00	Speech Pathology	0	143		0	4,331		4.00
5.00	Medical Social Services	0	4		0	27,897		5.00
6.00	Home Health Aide	0	227		0	34,438		6.00
7.00	Total (sum of lines 1-6)	0	3,701		0	839,394		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2019

Part I

To 12/31/2019

Date/Time Prepared:

8/27/2020 3:17 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
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		
			6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	16,662	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
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	457,986						1.00	
2.00	Physical Therapy	210,642						2.00	
3.00	Occupational Therapy	104,100						3.00	
4.00	Speech Pathology	4,331						4.00	
5.00	Medical Social Services	27,897						5.00	
6.00	Home Health Aide	34,438						6.00	
7.00	Total (sum of lines 1-6)	839,394						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/27/2020 3:17 pm

Title XVIII

Home Health
Agency I

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	0.262912	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.303199	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.465084	0	0	col. 2, line 4.00		3.00
3.01 Speech Pathology 1	68.01	0.250091	0	0	col. 2, line 4.01		3.01
4.00 Cost of Medical Supplies	71.00	0.606198	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.181342	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289 HHA CCN: 14-7420	Period: From 01/01/2019 To 12/31/2019	Worksheet H-4 Part I-II Date/Time Prepared: 8/27/2020 3:17 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	0	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	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	655,169
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	38,775
13.00	Total PPS Reimbursement - LUPA Episodes		0	25,024
14.00	Total PPS Reimbursement - PEP Episodes		0	12,633
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	8,291
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	53
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	739,945
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	739,945
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	739,945
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	739,945
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	739,945
31.01	Sequestration adjustment (see instructions)		0	14,799
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	725,146
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-0289
HHA CCN: 14-7420Period:
From 01/01/2019
To 12/31/2019

Worksheet H-5

Date/Time Prepared:
8/27/2020 3:17 pm

		Home Health Agency I		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		0		725,146
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
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		725,146
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		725,146
		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: 14-0289	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/27/2020 3:17 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,378,366	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,190	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)		63.12	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)		2.74	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		16.97	8.00
9.00	Sum of lines 7 and 8		19.71	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.07	10.00
11.00	Disproportionate share adjustment (see instructions)		56,099	11.00
12.00	Total prospective capital payments (see instructions)		1,438,655	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