

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 5/21/2020 9:52 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 5/21/2020	Time: 9:52 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVEREDGE HOSPITAL (14-4009) 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) STEVE FILTON

Officer or Administrator of Provider(s)

SVP & CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	15,942	-1	0	-602,001	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	15,942	-1	0	-602,001	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: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
5/21/2020 9:52 am

1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 8311 WEST ROOSEVELT RD			PO Box:						1.00	
2.00	City: FOREST PARK			State: IL		Zip Code: 60130		County: COOK		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	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		RIVEREDGE HOSPITAL	144009	16974	4	07/01/1967	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019		20.00	
21.00	Type of Control (see instructions)						4			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	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)					N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
			1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0	0	0	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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			
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 9:52 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	177,970	250,667	0	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB2125	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4009		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 9:52 am	
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: HIGHMARK HEALTH SERVICES		Contractor's Name: HIGHMARK HEALTH SERVICES		Contractor's Number: 12901		141.00		
142.00	Street: 120 FIFTH AVENUE		PO Box:				142.00		
143.00	City: PITTSBURGH		State: PA		Zip Code: 15222-3099		143.00		
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	
								1.00	
								2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	
				Part A		Part B		Title V	
				1.00		2.00		3.00	
								Title XIX	
				1.00		2.00		4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N		N		N	
156.00	Subprovider - IPF			N		N		N	
157.00	Subprovider - IRF			N		N		N	
158.00	SUBPROVIDER								
159.00	SNF			N		N		N	
160.00	HOME HEALTH AGENCY			N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	
				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.								N	
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	
								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		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 5/21/2020 9:52 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/07/2018	Y 03/07/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
5/21/2020 9:52 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	UHS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-312-5742	KEVIN.SMITH@UHSINC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 5/21/2020 9:52 am
		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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
5/21/2020 9:52 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	210	76,650	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)		210	76,650	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		210	76,650	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	14	5,110			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		224			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
5/21/2020 9:52 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,423	5,953	41,213			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,423	5,953	41,213			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)	5,423	5,953	41,213	0.00	259.20	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			4,475	0.00	14.30	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	273.50	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
5/21/2020 9:52 am

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	380	548	4,570	1.00
2.00 HMO and other (see instructions)			0	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	380	548	4,570	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				6	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-4009

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

Worksheet S-10

Date/Time Prepared:
5/21/2020 9:52 am

			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)		0.374921	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	0	0	0 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0 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)	0	0	0 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?			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)		0	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		167,692	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		257,987	27.01
28.00	Non-Medicare bad debt expense (see instructions)		-257,987	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		-6,430	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		-6,430	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		-6,430	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4009

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

Worksheet A

Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,692,408	2,692,408	0	2,692,408	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		204,317	204,317	2,839	207,156	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	189,223	3,330,467	3,519,690	0	3,519,690	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,596,464	7,162,096	10,758,560	-878,392	9,880,168	5.00
7.00	00700	OPERATION OF PLANT	7,697	1,146,448	1,154,145	0	1,154,145	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	245,473	245,473	0	245,473	8.00
9.00	00900	HOUSEKEEPING	0	693,604	693,604	0	693,604	9.00
10.00	01000	DIETARY	357,527	752,765	1,110,292	0	1,110,292	10.00
13.00	01300	NURSING ADMINISTRATION	854,090	30,127	884,217	0	884,217	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	343,982	251,423	595,405	0	595,405	16.00
17.00	01700	SOCIAL SERVICE	295,325	157,974	453,299	-453,299	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,540,274	302,083	8,842,357	377,603	9,219,960	30.00
46.00	04600	OTHER LONG TERM CARE	707,905	71,564	779,469	27,449	806,918	46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	149,541	149,541	0	149,541	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	783,200	783,200	0	783,200	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	638,880	23,534	662,414	26,289	688,703	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	428,918	20,360	449,278	21,958	471,236	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		15,960,285	18,017,384	33,977,669	-875,553	33,102,116	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SCHOOL	99,157	8,101	107,258		107,258	194.01
194.02	07953	COMMUNITY RELATIONS	0	0	0	565,297	565,297	194.02
194.03	07952	LEASED SPACE	0	0	0	0	0	194.03
194.04	07954	OP MEALS	0	0	0	0	0	194.04
194.05	07955	PT TRANSPORTATION	0	0	0	310,256	310,256	194.05
200.00	TOTAL (SUM OF LINES 118 through 199)		16,059,442	18,025,485	34,084,927	0	34,084,927	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4009

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

Worksheet A

Date/Time Prepared:
5/21/2020 9:52 am

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	-654,711	2,037,697	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-106,740	100,416	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-692,680	2,827,010	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,754,878	8,125,290	5.00
7.00	00700	OPERATION OF PLANT	0	1,154,145	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	245,473	8.00
9.00	00900	HOUSEKEEPING	0	693,604	9.00
10.00	01000	DIETARY	-18,142	1,092,150	10.00
13.00	01300	NURSING ADMINISTRATION	0	884,217	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-126	595,279	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	9,219,960	30.00
46.00	04600	OTHER LONG TERM CARE	0	806,918	46.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	149,541	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	783,200	73.00
76.00	03020	RECREATION THERAPY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	688,703	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	471,236	93.99
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,227,277	29,874,839	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	SCHOOL	0	107,258	194.01
194.02	07953	COMMUNITY RELATIONS	0	565,297	194.02
194.03	07952	LEASED SPACE	0	0	194.03
194.04	07954	OP MEALS	0	0	194.04
194.05	07955	PT TRANSPORTATION	0	310,256	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,227,277	30,857,650	200.00

RECLASSIFICATIONS

Provider CCN: 14-4009

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

Worksheet A-6

Date/Time Prepared:
5/21/2020 9:52 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,839	1.00
	TOTALS		0	2,839	
	B - COMMUNITY RELATIONS				
1.00	COMMUNITY RELATIONS	194.02	408,384	156,913	1.00
	TOTALS		408,384	156,913	
	C - RECREATION THERAPY				
1.00	ADULTS & PEDIATRICS	30.00	236,360	141,243	1.00
2.00	OTHER LONG TERM CARE	46.00	12,658	14,791	2.00
3.00	OTHER OUTPATIENT SERVICE	93.00	25,232	1,057	3.00
	COST CENTER				
4.00	PARTIAL HOSPITALIZATION	93.99	21,075	883	4.00
	PROGRAM				
	TOTALS		295,325	157,974	
	D - PT TRANSPORTATION				
1.00	PT TRANSPORTATION	194.05	226,776	83,480	1.00
	TOTALS		226,776	83,480	
500.00	Grand Total: Increases		930,485	401,206	500.00

RECLASSIFICATIONS

Provider CCN: 14-4009

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

Worksheet A-6

Date/Time Prepared:
5/21/2020 9:52 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RENT LEASE						
	ADMINISTRATIVE & GENERAL	5.00	0	2,839	10		1.00
	TOTALS		0	2,839			
1.00	B - COMMUNITY RELATIONS						
	ADMINISTRATIVE & GENERAL	5.00	408,384	156,913	0		1.00
	TOTALS		408,384	156,913			
1.00	C - RECREATION THERAPY						
	SOCIAL SERVICE	17.00	295,325	157,974	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
	TOTALS		295,325	157,974			
1.00	D - PT TRANSPORTATION						
	ADMINISTRATIVE & GENERAL	5.00	226,776	83,480	0		1.00
	TOTALS		226,776	83,480			
500.00	Grand Total: Decreases		930,485	401,206			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
5/21/2020 9:52 am

		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	0	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	3,597,655	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	1,283,211	0	0	0	0	6.00	
7.00	HIT designated Assets	15,775	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	4,896,641	0	0	0	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	4,896,641	0	0	0	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	3,597,655	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	1,283,211	0				6.00	
7.00	HIT designated Assets	15,775	0				7.00	
8.00	Subtotal (sum of lines 1-7)	4,896,641	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	4,896,641	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,757,736	0	0	20,207	914,465	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	195,155	0	0	9,162	0	2.00
3.00	Total (sum of lines 1-2)	1,952,891	0	0	29,369	914,465	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,692,408				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	204,317				2.00
3.00	Total (sum of lines 1-2)	0	2,896,725				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,103,025	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	156,515	2,839	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,259,540	2,839	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	20,207	914,465	0	2,037,697	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	-58,938	0	0	100,416	2.00
3.00	Total (sum of lines 1-2)	0	-38,731	914,465	0	2,138,113	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4009

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

Worksheet A-8

Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-89,945	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,577,315			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,204,391			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-18,142	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-126	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-654,711	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-38,640	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REVENUE	B	-31,175	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4009

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

Worksheet A-8

Date/Time Prepared:
5/21/2020 9:52 am

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	
33.01	NONALLOWABLE TRAVEL	A	-321	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN BILLING COST	A	-130,026	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	STATE INCOME TAX	A	-430,592	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DONATIONS	A	-3,350	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	GAIN LOSS ON ASSET DISPOSAL	A	-186	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	REBATES	B	89,945	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	BAD DEBTS	A	-824,255	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PT TRANSPORTATION	A	-68,100	CAP REL COSTS-MVBLE EQUIP	2.00	12	33.08
33.09	LOBBYING	A	-37,959	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PHYSICIAN BENEFITS	A	-548,763	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	MALPRACTICE	A	-68,007	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,227,277				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: 14-4009

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

Worksheet A-8-1

Date/Time Prepared:
5/21/2020 9:52 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST NRO	22,771	22,771 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1,568,615	1,424,880 2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP INSURANCE	224,172	368,089 3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	2,351,538	146,965 4.00
5.00	0			0	4,167,096	1,962,705 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	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	UNIVERSAL HEALT	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: 14-4009

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

Worksheet A-8-1

Date/Time Prepared:
5/21/2020 9:52 am

	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	0	0		1.00
2.00	143,735	0		2.00
3.00	-143,917	0		3.00
4.00	2,204,573	0		4.00
5.00	2,204,391			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	HEALTHCARE		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: 14-4009

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

Worksheet A-8-2

Date/Time Prepared:
5/21/2020 9:52 am

	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	AGGREGATE-ADMINISTRATIVE & GENERAL	2,615,667	2,491,348	124,319	181,300	440	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		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			2,615,667	2,491,348	124,319		440	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	AGGREGATE-ADMINISTRATIVE & GENERAL	38,352	1,918	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		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			38,352	1,918	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	AGGREGATE-ADMINISTRATIVE & GENERAL	0	38,352	85,967	2,577,315		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		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	38,352	85,967	2,577,315		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,037,697	2,037,697			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	100,416		100,416		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,827,010	12,321	633	2,839,964	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,125,290	324,029	16,638	529,922	8,995,879
7.00	00700	OPERATION OF PLANT	1,154,145	120,921	6,209	1,377	1,282,652
8.00	00800	LAUNDRY & LINEN SERVICE	245,473	23,440	1,204	0	270,117
9.00	00900	HOUSEKEEPING	693,604	25,095	1,289	0	719,988
10.00	01000	DIETARY	1,092,150	119,427	6,132	63,979	1,281,688
13.00	01300	NURSING ADMINISTRATION	884,217	114,563	5,883	152,839	1,157,502
16.00	01600	MEDICAL RECORDS & LIBRARY	595,279	22,414	1,151	61,555	680,399
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,219,960	1,017,633	52,254	1,570,575	11,860,422
46.00	04600	OTHER LONG TERM CARE	806,918	97,994	5,032	128,944	1,038,888
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	149,541	6,138	315	0	155,994
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	783,200	17,492	898	0	801,590
76.00	03020	RECREATION THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	688,703	8,101	416	118,842	816,062
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	471,236	4,483	230	80,526	556,475
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,874,839	1,914,051	98,284	2,708,559	29,617,656
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	SCHOOL	107,258	26,868	1,380	17,744	153,250
194.02	07953	COMMUNITY RELATIONS	565,297	14,650	752	73,080	653,779
194.03	07952	LEASED SPACE	0	82,128	0	0	82,128
194.04	07954	OP MEALS	0	0	0	0	0
194.05	07955	PT TRANSPORTATION	310,256	0	0	40,581	350,837
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	30,857,650	2,037,697	100,416	2,839,964	30,857,650

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,995,879				5.00
7.00	00700	OPERATION OF PLANT	527,797	1,810,449			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	111,150	26,852	408,119		8.00
9.00	00900	HOUSEKEEPING	296,267	28,748	0	1,045,003	9.00
10.00	01000	DIETARY	527,401	136,809	0	81,469	2,027,367
13.00	01300	NURSING ADMINISTRATION	476,299	131,237	0	78,151	0
16.00	01600	MEDICAL RECORDS & LIBRARY	279,977	25,677	0	15,290	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,880,433	1,165,742	368,145	694,194	1,684,963
46.00	04600	OTHER LONG TERM CARE	427,491	112,256	39,974	66,848	183,277
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	64,190	7,032	0	4,187	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	329,845	20,038	0	11,932	0
76.00	03020	RECREATION THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	335,801	9,281	0	5,527	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	228,983	5,135	0	3,058	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,485,634	1,668,807	408,119	960,656	1,868,240
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	SCHOOL	63,061	30,779	0	18,328	0
194.02	07953	COMMUNITY RELATIONS	269,023	16,782	0	9,994	0
194.03	07952	LEASED SPACE	33,795	94,081	0	56,025	0
194.04	07954	OP MEALS	0	0	0	0	159,127
194.05	07955	PT TRANSPORTATION	144,366	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	8,995,879	1,810,449	408,119	1,045,003	2,027,367

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	16.00	17.00	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
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
13.00	01300	NURSING ADMINISTRATION	1,843,189					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,001,343				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,638,305	787,846	0	23,080,050	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	42,192	0	1,910,926	0	46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	5,956	0	237,359	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,991	0	1,174,396	0	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	122,585	84,108	0	1,373,364	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	82,299	70,250	0	946,200	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,843,189	1,001,343	0	28,722,295	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SCHOOL	0	0	0	265,418	0	194.01
194.02	07953	COMMUNITY RELATIONS	0	0	0	949,578	0	194.02
194.03	07952	LEASED SPACE	0	0	0	266,029	0	194.03
194.04	07954	OP MEALS	0	0	0	159,127	0	194.04
194.05	07955	PT TRANSPORTATION	0	0	0	495,203	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,843,189	1,001,343	0	30,857,650	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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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
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
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	RECREATION THERAPY	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
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			
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	SCHOOL	194.01
194.02	07953	COMMUNITY RELATIONS	194.02
194.03	07952	LEASED SPACE	194.03
194.04	07954	OP MEALS	194.04
194.05	07955	PT TRANSPORTATION	194.05
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: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
5/21/2020 9:52 am

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	12,321	633	12,954	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,512	324,029	16,638	387,179	5.00
7.00	00700	OPERATION OF PLANT	0	120,921	6,209	127,130	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,440	1,204	24,644	8.00
9.00	00900	HOUSEKEEPING	0	25,095	1,289	26,384	9.00
10.00	01000	DIETARY	0	119,427	6,132	125,559	10.00
13.00	01300	NURSING ADMINISTRATION	0	114,563	5,883	120,446	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,414	1,151	23,565	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,017,633	52,254	1,069,887	30.00
46.00	04600	OTHER LONG TERM CARE	0	97,994	5,032	103,026	46.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	6,138	315	6,453	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,492	898	18,390	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	8,101	416	8,517	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	4,483	230	4,713	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,512	1,914,051	98,284	2,058,847	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	SCHOOL	0	26,868	1,380	28,248	194.01
194.02	07953	COMMUNITY RELATIONS	0	14,650	752	15,402	194.02
194.03	07952	LEASED SPACE	0	82,128	0	82,128	194.03
194.04	07954	OP MEALS	0	0	0	0	194.04
194.05	07955	PT TRANSPORTATION	0	0	0	0	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	46,512	2,037,697	100,416	2,184,625	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	389,595					5.00
7.00	00700	OPERATION OF PLANT	22,858	149,994				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,814	2,225	31,683			8.00
9.00	00900	HOUSEKEEPING	12,831	2,382	0	41,597		9.00
10.00	01000	DIETARY	22,841	11,334	0	3,243	163,269	10.00
13.00	01300	NURSING ADMINISTRATION	20,628	10,873	0	3,111	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,125	2,127	0	609	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	211,361	96,581	28,580	27,631	135,694	30.00
46.00	04600	OTHER LONG TERM CARE	18,514	9,300	3,103	2,661	14,760	46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	2,780	583	0	167	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,285	1,660	0	475	0	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	14,543	769	0	220	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	9,917	425	0	122	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	367,497	138,259	31,683	38,239	150,454	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SCHOOL	2,731	2,550	0	730	0	194.01
194.02	07953	COMMUNITY RELATIONS	11,651	1,390	0	398	0	194.02
194.03	07952	LEASED SPACE	1,464	7,795	0	2,230	0	194.03
194.04	07954	OP MEALS	0	0	0	0	12,815	194.04
194.05	07955	PT TRANSPORTATION	6,252	0	0	0	0	194.05
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)	389,595	149,994	31,683	41,597	163,269	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
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Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	16.00	17.00	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
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
13.00	01300	NURSING ADMINISTRATION	155,755					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,707				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	138,441	30,458	0	1,745,799	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	1,630	0	153,582	0	46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	230	0	10,213	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	425	0	35,235	0	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	10,359	3,250	0	38,200	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	6,955	2,714	0	25,213	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155,755	38,707	0	2,008,242	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SCHOOL	0	0	0	34,340	0	194.01
194.02	07953	COMMUNITY RELATIONS	0	0	0	29,174	0	194.02
194.03	07952	LEASED SPACE	0	0	0	93,617	0	194.03
194.04	07954	OP MEALS	0	0	0	12,815	0	194.04
194.05	07955	PT TRANSPORTATION	0	0	0	6,437	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	155,755	38,707	0	2,184,625	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4009

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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
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
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	RECREATION THERAPY	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
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			
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	SCHOOL	194.01
194.02	07953	COMMUNITY RELATIONS	194.02
194.03	07952	LEASED SPACE	194.03
194.04	07954	OP MEALS	194.04
194.05	07955	PT TRANSPORTATION	194.05
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: 14-4009

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (PHYS SQ FT)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	139,092					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		133,486				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	841	841	15,870,219			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,118	22,118	2,961,304	-8,995,879	21,861,771	5.00
7.00	00700	OPERATION OF PLANT	8,254	8,254	7,697	0	1,282,652	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,600	1,600	0	0	270,117	8.00
9.00	00900	HOUSEKEEPING	1,713	1,713	0	0	719,988	9.00
10.00	01000	DIETARY	8,152	8,152	357,527	0	1,281,688	10.00
13.00	01300	NURSING ADMINISTRATION	7,820	7,820	854,090	0	1,157,502	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,530	1,530	343,982	0	680,399	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	69,463	69,463	8,776,634	0	11,860,422	30.00
46.00	04600	OTHER LONG TERM CARE	6,689	6,689	720,563	0	1,038,888	46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	419	419	0	0	155,994	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,194	1,194	0	0	801,590	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	553	553	664,112	0	816,062	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	306	306	449,993	0	556,475	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,652	130,652	15,135,902	-8,995,879	20,621,777	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SCHOOL	1,834	1,834	99,157	0	153,250	194.01
194.02	07953	COMMUNITY RELATIONS	1,000	1,000	408,384	0	653,779	194.02
194.03	07952	LEASED SPACE	5,606	0	0	0	82,128	194.03
194.04	07954	OP MEALS	0	0	0	0	0	194.04
194.05	07955	PT TRANSPORTATION	0	0	226,776	0	350,837	194.05
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)	2,037,697	100,416	2,839,964		8,995,879	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.649994	0.752259	0.178949		0.411489	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,954		389,595	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000816		0.017821	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: 14-4009

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (NURSING MANHOURS)	
			7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	107,879					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,600	45,688				8.00
9.00	00900	HOUSEKEEPING	1,713	0	104,566			9.00
10.00	01000	DIETARY	8,152	0	8,152	148,504		10.00
13.00	01300	NURSING ADMINISTRATION	7,820	0	7,820	0	9,608	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,530	0	1,530	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	69,463	41,213	69,463	123,423	8,540	30.00
46.00	04600	OTHER LONG TERM CARE	6,689	4,475	6,689	13,425	0	46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	419	0	419	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,194	0	1,194	0	0	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	553	0	553	0	639	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	306	0	306	0	429	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,439	45,688	96,126	136,848	9,608	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SCHOOL	1,834	0	1,834	0	0	194.01
194.02	07953	COMMUNITY RELATIONS	1,000	0	1,000	0	0	194.02
194.03	07952	LEASED SPACE	5,606	0	5,606	0	0	194.03
194.04	07954	OP MEALS	0	0	0	11,656	0	194.04
194.05	07955	PT TRANSPORTATION	0	0	0	0	0	194.05
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)	1,810,449	408,119	1,045,003	2,027,367	1,843,189	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.782219	8.932739	9.993717	13.651935	191.838988	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	149,994	31,683	41,597	163,269	155,755	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.390391	0.693464	0.397806	1.099425	16.210970	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: 14-4009

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76,608,859		16.00
17.00	01700	SOCIAL SERVICE	0	45,688	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	60,275,204	41,213	30.00
46.00	04600	OTHER LONG TERM CARE	3,227,922	4,475	46.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	455,676	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	840,870	0	73.00
76.00	03020	RECREATION THERAPY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	6,434,667	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	5,374,520	0	93.99
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,608,859	45,688	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	SCHOOL	0	0	194.01
194.02	07953	COMMUNITY RELATIONS	0	0	194.02
194.03	07952	LEASED SPACE	0	0	194.03
194.04	07954	OP MEALS	0	0	194.04
194.05	07955	PT TRANSPORTATION	0	0	194.05
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)	1,001,343	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013071	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,707	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000505	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/21/2020 9:52 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	23,080,050		23,080,050	0	23,080,050	30.00	
46.00	04600	OTHER LONG TERM CARE	1,910,926		1,910,926	0	1,910,926	46.00	
ANCILLARY SERVICE COST CENTERS									
60.00	06000	LABORATORY	237,359		237,359	0	237,359	60.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,174,396		1,174,396	0	1,174,396	73.00	
76.00	03020	RECREATION THERAPY	0		0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	0		0	0	0	91.00	
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	1,373,364		1,373,364	0	1,373,364	93.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	946,200		946,200	0	946,200	93.99	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	28,722,295	0	28,722,295	0	28,722,295	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	28,722,295	0	28,722,295	0	28,722,295	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/21/2020 9:52 am

					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	60,275,204		60,275,204			30.00
46.00	04600	OTHER LONG TERM CARE	3,227,922		3,227,922			46.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	455,676	0	455,676	0.520894	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	840,870	0	840,870	1.396644	0.000000	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0.000000	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	6,434,667	6,434,667	0.213432	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	5,374,520	5,374,520	0.176053	0.000000	93.99
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	64,799,672	11,809,187	76,608,859			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	64,799,672	11,809,187	76,608,859			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0.520894			60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.396644			73.00
76.00	03020	RECREATION THERAPY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.213432			93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.176053			93.99
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/21/2020 9:52 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,080,050		23,080,050	0	23,080,050	30.00
46.00	04600	OTHER LONG TERM CARE	1,910,926		1,910,926	0	1,910,926	46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	237,359		237,359	0	237,359	60.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,174,396		1,174,396	0	1,174,396	73.00
76.00	03020	RECREATION THERAPY	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	1,373,364		1,373,364	0	1,373,364	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	946,200		946,200	0	946,200	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,722,295	0	28,722,295	0	28,722,295	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	28,722,295	0	28,722,295	0	28,722,295	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/21/2020 9:52 am

				Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	60,275,204		60,275,204			30.00
46.00	04600	OTHER LONG TERM CARE	3,227,922		3,227,922			46.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	455,676	0	455,676	0.520894	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	840,870	0	840,870	1.396644	0.000000	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0.000000	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	6,434,667	6,434,667	0.213432	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	5,374,520	5,374,520	0.176053	0.000000	93.99
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	64,799,672	11,809,187	76,608,859			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	64,799,672	11,809,187	76,608,859			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0.000000			60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	RECREATION THERAPY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
5/21/2020 9:52 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,745,799	0	1,745,799	41,213	42.36	30.00
200.00	Total (lines 30 through 199)	1,745,799		1,745,799	41,213		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,423	229,718				
200.00	Total (lines 30 through 199)	5,423	229,718				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	10,213	455,676	0.022413	13,613	305
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	35,235	840,870	0.041903	166,262	6,967
76.00	03020	RECREATION THERAPY	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	0	0	0.000000	0	0
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	38,200	6,434,667	0.005937	0	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	25,213	5,374,520	0.004691	0	0
200.00		Total (lines 50 through 199)	108,861	13,105,733		179,875	7,272

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-4009		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 5/21/2020 9:52 am		
					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		
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	41,213	0.00	5,423	30.00			
200.00		Total (lines 30 through 199)	0	0	41,213		5,423	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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-4009		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 5/21/2020 9:52 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
60.00	06000	LABORATORY		0	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.00	03020	RECREATION THERAPY		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER		0	0	0	0	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
5/21/2020 9:52 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	455,676	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	840,870	0.000000	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	6,434,667	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	5,374,520	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	13,105,733		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-4009		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 5/21/2020 9:52 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
60.00	06000	LABORATORY		0.000000	13,613	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	166,262	0	0	0	73.00
76.00	03020	RECREATION THERAPY		0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER		0.000000	0	0	246,460	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	205,855	0	93.99
200.00		Total (lines 50 through 199)			179,875	0	452,315	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
5/21/2020 9:52 am

			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								
60.00	06000	LABORATORY	0.520894	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.396644	0	0	0	0	73.00
76.00	03020	RECREATION THERAPY	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.213432	246,460	0	0	52,602	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.176053	205,855	0	0	36,241	93.99
200.00		Subtotal (see instructions)		452,315	0	0	88,843	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		452,315	0	0	88,843	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
5/21/2020 9:52 am

				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					
60.00	06000	LABORATORY	0	0		60.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	RECREATION THERAPY	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-4009		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 5/21/2020 9:52 am		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	41,213	0.00	5,953	30.00			
200.00		Total (lines 30 through 199)	0	0	41,213		5,953	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	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-4009

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XIX		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
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Cost Center Description			Title XIX		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	455,676	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	840,870	0.000000
76.00	03020	RECREATION THERAPY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	0	0.000000
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	6,434,667	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	5,374,520	0.000000
200.00		Total (lines 50 through 199)	0	0	0	13,105,733	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
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Cost Center Description			Title XIX		Hospital	Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0.000000	65,348	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	120,588	0	0	0
76.00	03020	RECREATION THERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	0	0	0	0
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		185,936	0	0	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 5/21/2020 9:52 am
		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)		41,213	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		41,213	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)		41,213	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)		5,423	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)		23,080,050	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)		23,080,050	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)		23,080,050	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)		560.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,036,988	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,036,988	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4009

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

Worksheet D-1

Date/Time Prepared:
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		Title XVIII		Hospital		PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					239,300	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,276,288	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)					229,718	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					7,272	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					236,990	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,039,298	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: 14-4009

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

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		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,745,799	23,080,050	0.075641	0	0	90.00
91.00 Nursing School cost	0	23,080,050	0.000000	0	0	91.00
92.00 Allied health cost	0	23,080,050	0.000000	0	0	92.00
93.00 All other Medical Education	0	23,080,050	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4009

Period:
From 01/01/2019
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Worksheet D-1

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Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	41,213	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	41,213	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)	41,213	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)	5,953	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)	23,080,050	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)	23,080,050	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)	23,080,050	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)	560.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,333,799	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,333,799	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4009

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

Worksheet D-1

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Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						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)					202,458	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,536,257	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4009

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

Worksheet D-1

Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,745,799	23,080,050	0.075641	0	0	90.00
91.00	Nursing School cost	0	23,080,050	0.000000	0	0	91.00
92.00	Allied health cost	0	23,080,050	0.000000	0	0	92.00
93.00	All other Medical Education	0	23,080,050	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 5/21/2020 9:52 am	
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		7,917,580		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.520894	13,613	7,091	60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.396644	166,262	232,209	73.00
76.00	03020 RECREATION THERAPY	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.213432	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.176053	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		179,875	239,300	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)		179,875		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 5/21/2020 9:52 am	
Cost Center Description		Title XIX	Hospital	Cost	
		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		8,643,972		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.520894	65,348	34,039	60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.396644	120,588	168,419	73.00
76.00	03020 RECREATION THERAPY	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.213432	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.176053	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		185,936	202,458	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)		185,936		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 5/21/2020 9:52 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		88,843	2.00
3.00	OPPS payments		172,360	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		172,360	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		42,855	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	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)		129,505	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)		129,505	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		129,505	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		129,505	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		129,505	40.00
40.01	Sequestration adjustment (see instructions)		2,590	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		126,916	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
5/21/2020 9:52 am

		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		4,412,317		126,916	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	09/03/2019	47,364		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)		-47,364		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)		4,364,953		126,916	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		15,942		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		4,380,895		126,915	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		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 5/21/2020 9:52 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS					
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		4,795,203	1.00	
2.00	Net IPF PPS Outlier Payments		0	2.00	
3.00	Net IPF PPS ECT Payments		0	3.00	
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00	
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01	
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00	
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)		0.00	6.00	
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)		0.00	7.00	
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00	
9.00	Average Daily Census (see instructions)		112.912329	9.00	
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.		0.000000	10.00	
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00	
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		4,795,203	12.00	
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00	
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00	
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00	
16.00	Subtotal (see instructions)		4,795,203	16.00	
17.00	Primary payer payments		0	17.00	
18.00	Subtotal (line 16 less line 17).		4,795,203	18.00	
19.00	Deductibles		317,620	19.00	
20.00	Subtotal (line 18 minus line 19)		4,477,583	20.00	
21.00	Coinurance		174,974	21.00	
22.00	Subtotal (line 20 minus line 21)		4,302,609	22.00	
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		257,987	23.00	
24.00	Adjusted reimbursable bad debts (see instructions)		167,692	24.00	
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		173,903	25.00	
26.00	Subtotal (sum of lines 22 and 24)		4,470,301	26.00	
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00	
28.00	Other pass through costs (see instructions)		0	28.00	
29.00	Outlier payments reconciliation		0	29.00	
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00	
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50	
30.99	Demonstration payment adjustment amount before sequestration		0	30.99	
31.00	Total amount payable to the provider (see instructions)		4,470,301	31.00	
31.01	Sequestration adjustment (see instructions)		89,406	31.01	
31.02	Demonstration payment adjustment amount after sequestration		0	31.02	
32.00	Interim payments		4,364,953	32.00	
33.00	Tentative settlement (for contractor use only)		0	33.00	
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		15,942	34.00	
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00	
TO BE COMPLETED BY CONTRACTOR					
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00	
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00	
52.00	The rate used to calculate the Time Value of Money		0.00	52.00	
53.00	Time Value of Money (see instructions)		0	53.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4009	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 5/21/2020 9:52 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		3,536,257		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,536,257	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,536,257	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		7,578,694		8.00
9.00	Ancillary service charges		185,936	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		7,764,630	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		7,764,630	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,228,373	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3,536,257	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		3,536,257	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3,536,257	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3,536,257	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		3,536,257	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,536,257	0	40.00
41.00	Interim payments		4,138,258	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-602,001	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-4009

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

Worksheet G

Date/Time Prepared:
5/21/2020 9:52 am

		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	-429,920	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,822,828	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	150,788	0	0	0	7.00
8.00	Prepaid expenses	44,201	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,587,897	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,613,150	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	23,404,068	0	0	0	15.00
16.00	Accumulated depreciation	-13,162,387	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,965,534	0	0	0	23.00
24.00	Accumulated depreciation	-1,368,015	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,452,350	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	53,652,264	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	53,652,264	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	72,692,511	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	725,875	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,451,514	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-21,843,866	0	0	0	43.00
44.00	Other current liabilities	226,019	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-18,440,458	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-18,440,458	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	91,132,972				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	91,132,972	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	72,692,514	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4009

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

Worksheet G-1

Date/Time Prepared:
5/21/2020 9:52 am

		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		79,308,682		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,824,189				2.00
3.00	Total (sum of line 1 and line 2)		91,132,871		0		3.00
4.00	CONSOLIDATING ENTRIES	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)		91,132,871		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		91,132,871		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	CONSOLIDATING ENTRIES		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-4009

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
5/21/2020 9:52 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	60,275,204		60,275,204	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	3,227,922		3,227,922	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	63,503,126		63,503,126	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	63,503,126		63,503,126	17.00
18.00	Ancillary services	1,296,547	0	1,296,547	18.00
19.00	Outpatient services	0	11,809,187	11,809,187	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	64,799,673	11,809,187	76,608,860	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,084,927		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	PHYSICIAN REVENUE	5,296,347			37.00
38.00	SCHOOL REVENUE	266,317			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)		5,562,664		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,522,263		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4009

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

Worksheet G-3

Date/Time Prepared:
5/21/2020 9:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	76,608,860	1.00
2.00	Less contractual allowances and discounts on patients' accounts	36,316,341	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,292,519	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,522,263	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,770,256	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	53,933	24.00
25.00	Total other income (sum of lines 6-24)	53,933	25.00
26.00	Total (line 5 plus line 25)	11,824,189	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,824,189	29.00