

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: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/27/2020 1:44 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/27/2020	Time: 1:44 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH DEPAUL HOSPITAL (26-0104) 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) EILEEN LAMM

Officer or Administrator of Provider(s)

VP OF FINANCE

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	1,227,290	-18,483	0	0	1.00
2.00	Subprovider - IPF	0	-30,349	1		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	3,602	0		0	7.00
200.00	Total	0	1,200,543	-18,482	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 26-0104		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 1:44 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 12303 DEPAUL DRIVE			PO Box:				1.00		
2.00	City: BRIDGETON			State: MO		Zip Code: 63044		County: ST. LOUIS		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		SSM HEALTH DEPAUL HOSPITAL	260104	41180	1	01/01/1966	N	P	O
4.00	Subprovider - IPF		SSM HEALTH DEPAUL HOSPITAL	26S104	41180	4	07/01/1985	N	P	O
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		SSM HEALTH DEPAUL HOSPITAL-ANN HOUSE	265842	41180		09/11/2012	N	P	P
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019		20.00
21.00	Type of Control (see instructions)						1			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

Worksheet S-2
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

MCRIF32 - 16.2.168.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0104		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 1:44 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	N			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
						1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	357,829		25,000		0118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00		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	

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		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		269020		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: SSM HEALTH CARE CORP	Contractor's Name: WPS		Contractor's Number: 05301		141.00	
142.00	Street: 10101 WOODFIELD LANE	PO Box: PO BOX 86				142.00	
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132		143.00	
		1.00		2.00			
144.00	Are provider based physicians' costs included in worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y		11/19/2019		146.00	
		1.00		2.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
		Title V		Title XIX			
		1.00		2.00		3.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
		1.00		2.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		0		1.00		2.00	
		Zip Code		CBSA		FTE/Campus	
		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00 166.00	
		1.00		2.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 1:44 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 1:44 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		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	04/29/2020	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 1:44 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		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.		Y	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.	BRIAN	SCHMEIDLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3524	BRIAN.SCHMEIDLER@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 1:44 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIR- GOVERNMENT REIMBURSEME		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: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	353	128,845	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)		353	128,845	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	56	20,440	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		409	149,285	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	26	9,490		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	52	18,980		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		487			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: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	24,986	12,613	60,478			1.00
2.00	HMO and other (see instructions)	21,250	13,192				2.00
3.00	HMO IPF Subprovider	0	173				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)	24,986	12,613	60,478			7.00
8.00	INTENSIVE CARE UNIT	1,892	1,532	15,447			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		228	2,227			13.00
14.00	Total (see instructions)	26,878	14,373	78,152	15.00	1,566.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,912	9,873	27,681	0.00	12.56	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,872	12,383	16,961	0.00	60.65	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				15.00	1,639.63	27.00
28.00	Observation Bed Days		857	11,811			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1,317			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	352	461			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: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,068	2,999	22,947	1.00
2.00 HMO and other (see instructions)			3,843	2,685		2.00
3.00 HMO IPF Subprovider				45		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	5,068	2,999	22,947	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	317	296	1,179	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/27/2020 1:44 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	128,485,116	0	128,485,116	3,410,438.44	37.67
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		496,688	0	496,688	4,047.82	122.71
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		4,237,592	0	4,237,592	27,828.67	152.27
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	1,046,809	0	1,046,809	31,731.05	32.99
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	2,351,231	0	2,351,231	126,157.19	18.64
10.00	Excluded area salaries (see instructions)		8,035,074	-6,015,425	2,019,649	40,192.76	50.25
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		10,925,934	0	10,925,934	188,674.57	57.91
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		711,267	0	711,267	4,725.52	150.52
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		23,163,998	0	23,163,998	637,447.73	36.34
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		44,805,737	0	44,805,737		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,896,621	0	1,896,621		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		63,867	0	63,867		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		544,891	0	544,891		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		126,831	0	126,831		
25.50	Home office wage-related (core)		8,029,675	0	8,029,675		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/27/2020 1:44 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	315,984	0	315,984	11,909.89	26.53	26.00
27.00	Administrative & General	5.00	10,455,950	-352,672	10,103,278	257,308.50	39.27	27.00
28.00	Administrative & General under contract (see inst.)		1,239,556	0	1,239,556	12,959.17	95.65	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,688,217	0	1,688,217	49,539.38	34.08	30.00
31.00	Laundry & Linen Service	8.00	135,285	0	135,285	8,045.90	16.81	31.00
32.00	Housekeeping	9.00	2,687,910	0	2,687,910	161,904.21	16.60	32.00
33.00	Housekeeping under contract (see instructions)		411,859	0	411,859	13,976.00	29.47	33.00
34.00	Dietary	10.00	2,629,947	-1,763,512	866,435	38,212.32	22.67	34.00
35.00	Dietary under contract (see instructions)		480,597	0	480,597	16,149.00	29.76	35.00
36.00	Cafeteria	11.00	0	1,763,512	1,763,512	115,771.12	15.23	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,466,720	0	2,466,720	61,092.60	40.38	38.00
39.00	Central Services and Supply	14.00	321,394	352,672	674,066	34,379.78	19.61	39.00
40.00	Pharmacy	15.00	5,457,983	23,526	5,481,509	115,317.68	47.53	40.00
41.00	Medical Records & Medical Records Library	16.00	410,341	0	410,341	19,038.28	21.55	41.00
42.00	Social Service	17.00	412,348	0	412,348	8,654.43	47.65	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/27/2020 1:44 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	125,332,727	0	125,332,727	3,393,962.89	36.93	1.00
2.00	Excluded area salaries (see instructions)	10,386,305	-6,015,425	4,370,880	166,349.95	26.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)	114,946,422	6,015,425	120,961,847	3,227,612.94	37.48	3.00
4.00	Subtotal other wages & related costs (see inst.)	34,801,199	0	34,801,199	830,847.82	41.89	4.00
5.00	Subtotal wage-related costs (see inst.)	52,899,279	0	52,899,279	0.00	43.73	5.00
6.00	Total (sum of lines 3 thru 5)	202,646,900	6,015,425	208,662,325	4,058,460.76	51.41	6.00
7.00	Total overhead cost (see instructions)	29,114,091	23,526	29,137,617	924,258.26	31.53	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/27/2020 1:44 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,281,872	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	7,229,922	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	17,772,582	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	5,747,192	9.00
10.00	Dental, Hearing and Vision Plan	1,076,909	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	395,530	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	411,400	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,559,107	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	8,554,194	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	186,388	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	559,793	22.00
23.00	Tuition Reimbursement	663,058	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	47,437,947	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	11,933,226	47,437,947	1.00
2.00	Hospital	10,925,934	46,042,906	2.00
3.00	Subprovider - IPF	144,625	526,944	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	862,667	868,097	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/27/2020 1:44 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.256503		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		38,197,278		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,136,075		5.00
6.00	Medicaid charges		191,259,505		6.00
7.00	Medicaid cost (line 1 times line 6)		49,058,637		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)		9,725,284		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)		9,725,284		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)	58,891,683	7,594,534	66,486,217	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	15,105,893	7,594,534	22,700,427	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)	15,105,893	7,594,534	22,700,427	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		24,191,315		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,715,777		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,639,659		27.01
28.00	Non-Medicare bad debt expense (see instructions)		21,551,656		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		6,451,946		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		29,152,373		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		38,877,657		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0104

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

Worksheet A

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,101,313	8,101,313	-52,919	8,048,394	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,730,873	6,730,873	0	6,730,873	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	315,984	32,255,631	32,571,615	52,919	32,624,534	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,455,950	83,836,677	94,292,627	-1,144,956	93,147,671	5.00
7.00	00700	OPERATION OF PLANT	1,688,217	9,618,331	11,306,548	0	11,306,548	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	135,285	663,338	798,623	0	798,623	8.00
9.00	00900	HOUSEKEEPING	2,687,910	1,656,045	4,343,955	0	4,343,955	9.00
10.00	01000	DIETARY	2,629,947	5,273,658	7,903,605	-5,302,432	2,601,173	10.00
11.00	01100	CAFETERIA	0	0	0	5,299,766	5,299,766	11.00
13.00	01300	NURSING ADMINISTRATION	2,466,720	997,722	3,464,442	0	3,464,442	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	321,394	1,087,535	1,408,929	1,144,956	2,553,885	14.00
15.00	01500	PHARMACY	5,457,983	42,724,525	48,182,508	-40,705,438	7,477,070	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	410,341	206,535	616,876	0	616,876	16.00
17.00	01700	SOCIAL SERVICE	412,348	253,290	665,638	-5,285	660,353	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,046,809	79,047	1,125,856	-79,047	1,046,809	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	79,047	79,047	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	381,844	21,692	403,536	-23,526	380,010	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,392,322	6,252,656	40,644,978	4,076,676	44,721,654	30.00
31.00	03100	INTENSIVE CARE UNIT	7,084,190	3,598,027	10,682,217	-312,717	10,369,500	31.00
40.00	04000	SUBPROVIDER - IPF	7,419,122	2,566,862	9,985,984	-8,577,707	1,408,277	40.00
43.00	04300	NURSERY	260,175	0	260,175	1,553,765	1,813,940	43.00
44.00	04400	SKILLED NURSING FACILITY	2,351,231	1,949,481	4,300,712	-172,675	4,128,037	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,299,931	29,452,972	37,752,903	-23,556,021	14,196,882	50.00
51.00	05100	RECOVERY ROOM	912,458	189,454	1,101,912	-39,468	1,062,444	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,094,196	600,115	3,694,311	-1,457,401	2,236,910	52.00
52.01	05201	PERINATAL CLINIC	687,553	635,680	1,323,233	-11,805	1,311,428	52.01
53.00	05300	ANESTHESIOLOGY	79,355	4,282,709	4,362,064	-560,167	3,801,897	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,420,142	9,380,254	12,800,396	-4,679,251	8,121,145	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,269,137	960,030	3,229,167	-17,682	3,211,485	55.00
56.00	05600	RADIOISOTOPE	249,681	949,073	1,198,754	-6,162	1,192,592	56.00
57.00	05700	CT SCAN	876,587	698,927	1,575,514	-216,103	1,359,411	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	336,020	136,156	472,176	-22,875	449,301	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,399,963	11,650,037	13,050,000	-11,175,987	1,874,013	59.00
60.00	06000	LABORATORY	2,068,098	3,209,235	5,277,333	-43,219	5,234,114	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	422,644	1,323,795	1,746,439	1,201,200	2,947,639	62.00
64.00	06400	INTRAVENOUS THERAPY	1,932,135	981,137	2,913,272	-363,421	2,549,851	64.00
65.00	06500	RESPIRATORY THERAPY	2,502,556	1,290,471	3,793,027	-349,442	3,443,585	65.00
66.00	06600	PHYSICAL THERAPY	0	2,389,760	2,389,760	-16,376	2,373,384	66.00
66.01	06601	CLINICAL NUTRITION	706,736	2,554	709,290	-43	709,247	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,041,422	1,041,422	-22,327	1,019,095	67.00
68.00	06800	SPEECH PATHOLOGY	0	489,684	489,684	-907	488,777	68.00
69.00	06900	ELECTROCARDIOLOGY	2,926,243	2,218,359	5,144,602	-988,885	4,155,717	69.00
69.01	06901	CARDIAC REHABILITATION	301,012	11,072	312,084	-2,840	309,244	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	304,541	124,829	429,370	-53,469	375,901	70.00
70.01	07001	ELECTROSHOCK THERAPY	103,197	14,353	117,550	-12,390	105,160	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	29,090,101	29,090,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,642,869	19,642,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	41,055,786	41,055,786	73.00
74.00	07400	RENAL DIALYSIS	1,217	1,904,217	1,905,434	-43,844	1,861,590	74.00
76.00	03330	ENDOSCOPY	933,944	973,414	1,907,358	-668,755	1,238,603	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,646,566	5,371,864	11,018,430	-1,226,007	9,792,423	90.00
91.00	09100	EMERGENCY	8,859,324	4,756,066	13,615,390	-1,285,536	12,329,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,251,008	292,910,877	421,161,885	0	421,161,885	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,586	71,934	118,520	0	118,520	190.00
191.00	19100	RESEARCH	91,875	0	91,875	0	91,875	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	95,647	10,456	106,103	0	106,103	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	17,756,662	17,756,662	0	17,756,662	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	128,485,116	310,749,929	439,235,045	0	439,235,045	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0104

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

Worksheet A

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	148,278	8,196,672	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,956,301	8,687,174	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	24,281,310	56,905,844	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,388,438	78,759,233	5.00
7.00	00700	OPERATION OF PLANT	-1,233,513	10,073,035	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	798,623	8.00
9.00	00900	HOUSEKEEPING	-1,451	4,342,504	9.00
10.00	01000	DIETARY	-2,753	2,598,420	10.00
11.00	01100	CAFETERIA	-1,764,282	3,535,484	11.00
13.00	01300	NURSING ADMINISTRATION	-38,656	3,425,786	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3	2,553,882	14.00
15.00	01500	PHARMACY	-14,965	7,462,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,770	615,106	16.00
17.00	01700	SOCIAL SERVICE	-70,029	590,324	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,046,809	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	79,047	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	-5	380,005	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-8,202,006	36,519,648	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,780,010	8,589,490	31.00
40.00	04000	SUBPROVIDER - IPF	-1,449,957	-41,680	40.00
43.00	04300	NURSERY	0	1,813,940	43.00
44.00	04400	SKILLED NURSING FACILITY	-138,350	3,989,687	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-38,924	14,157,958	50.00
51.00	05100	RECOVERY ROOM	-57	1,062,387	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-10,211	2,226,699	52.00
52.01	05201	PERINATAL CLINIC	-604,978	706,450	52.01
53.00	05300	ANESTHESIOLOGY	-3,140,477	661,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-470,722	7,650,423	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-47,659	3,163,826	55.00
56.00	05600	RADIOISOTOPE	-3,094	1,189,498	56.00
57.00	05700	CT SCAN	-94,843	1,264,568	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-27,087	422,214	58.00
59.00	05900	CARDIAC CATHETERIZATION	-30,674	1,843,339	59.00
60.00	06000	LABORATORY	-2,114,926	3,119,188	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	-65,663	2,881,976	62.00
64.00	06400	INTRAVENOUS THERAPY	-106,723	2,443,128	64.00
65.00	06500	RESPIRATORY THERAPY	-9,863	3,433,722	65.00
66.00	06600	PHYSICAL THERAPY	-56	2,373,328	66.00
66.01	06601	CLINICAL NUTRITION	-74,291	634,956	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,019,095	67.00
68.00	06800	SPEECH PATHOLOGY	-74	488,703	68.00
69.00	06900	ELECTROCARDIOLOGY	-413,090	3,742,627	69.00
69.01	06901	CARDIAC REHABILITATION	-31,182	278,062	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-58,686	317,215	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	105,160	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,002,163	27,087,938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,642,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	41,055,786	73.00
74.00	07400	RENAL DIALYSIS	-1,353	1,860,237	74.00
76.00	03330	ENDOSCOPY	-3,713	1,234,890	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,372,821	7,419,602	90.00
91.00	09100	EMERGENCY	-2,121,817	10,208,037	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,545,446	404,616,439	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	118,520	190.00
191.00	19100	RESEARCH	0	91,875	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	106,103	194.00
194.01	07952	NONREIMBURSABLE	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	17,756,662	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,545,446	422,689,599	200.00

RECLASSIFICATIONS

Provider CCN: 26-0104

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

Worksheet A-6

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PHARMACY					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	2,329,248		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	41,055,786		2.00
3.00		0.00	0	0		3.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	43,385,034		
	B - NURSERY & L&D					
1.00	ADULTS & PEDIATRICS	30.00	2,273,234	693,204		1.00
2.00	INTENSIVE CARE UNIT	31.00	1,089,552	214,884		2.00
3.00	SUBPROVIDER - IPF	40.00	287	40		3.00
4.00	NURSERY	43.00	1,597,759	123,138		4.00
5.00		0.00	0	0		5.00
	TOTALS		4,960,832	1,031,266		
	C - CENTRAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	29,090,101		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	19,642,869		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
	TOTALS		0	48,732,970		
	D - BHM - DEPT					
1.00	ADULTS & PEDIATRICS	30.00	1,423,462	970,445		1.00
2.00		0.00	0	0		2.00
	TOTALS		1,423,462	970,445		

RECLASSIFICATIONS

Provider CCN: 26-0104

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

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Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	E - BHM - ADMIN					
1.00	ADULTS & PEDIATRICS	30.00	3,014,971	1,024,377	1.00	
2.00	CLINIC	90.00	193,228	65,652	2.00	
	TOTALS		3,208,199	1,090,029		
	F - PARKING GARAGE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	52,919	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	52,919		
	G - CENTRAL DISTRIBUTION					
1.00	CENTRAL SERVICES & SUPPLY	14.00	352,672	792,284	1.00	
	TOTALS		352,672	792,284		
	H - RESIDENCY ANCILLARY					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	79,047	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	79,047		
	I - PHARMACY RESIDENCY					
1.00	PHARMACY	15.00	23,526	0	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		23,526	0		
	J - DIETARY					
1.00	CAFETERIA	11.00	1,763,512	3,536,254	1.00	
	TOTALS		1,763,512	3,536,254		
500.00	Grand Total: Increases		11,732,203	99,670,248	500.00	

RECLASSIFICATIONS

Provider CCN: 26-0104

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

Worksheet A-6

Date/Time Prepared:
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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PHARMACY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	DIETARY	10.00	0	2,666	0		3.00
5.00	PHARMACY	15.00	0	40,728,964	0		5.00
6.00	SOCIAL SERVICE	17.00	0	5,285	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	785	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	219	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	1,436	0		9.00
10.00	SKILLED NURSING FACILITY	44.00	0	126,176	0		10.00
11.00	OPERATING ROOM	50.00	0	829	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	44	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,846	0		13.00
14.00	RADIOISOTOPE	56.00	0	592	0		14.00
16.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	1,127,782	0		16.00
17.00	INTRAVENOUS THERAPY	64.00	0	1,170	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	824	0		18.00
19.00	CARDIAC REHABILITATION	69.01	0	176	0		19.00
20.00	ENDOSCOPY	76.00	0	4	0		20.00
21.00	CLINIC	90.00	0	1,381,966	0		21.00
22.00	EMERGENCY	91.00	0	270	0		22.00
	TOTALS		0	43,385,034			
	B - NURSERY & L&D						
1.00	ADULTS & PEDIATRICS	30.00	2,292,639	261,460	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	176,340	96,361	0		2.00
3.00	SUBPROVIDER - IPF	40.00	1,360,525	486,441	0		3.00
4.00	NURSERY	43.00	167,132	0	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	964,196	187,004	0		5.00
	TOTALS		4,960,832	1,031,266			
	C - CENTRAL SUPPLY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,768,133	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	1,344,233	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	37,497	0		5.00
7.00	SKILLED NURSING FACILITY	44.00	0	46,499	0		7.00
8.00	OPERATING ROOM	50.00	0	23,555,192	0		8.00
9.00	RECOVERY ROOM	51.00	0	39,468	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	306,157	0		10.00
11.00	PERINATAL CLINIC	52.01	0	11,805	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	560,167	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,673,405	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	17,682	0		14.00
15.00	RADIOISOTOPE	56.00	0	5,570	0		15.00
16.00	CT SCAN	57.00	0	216,103	0		16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	22,875	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	11,175,987	0		18.00
19.00	LABORATORY	60.00	0	43,219	0		19.00
20.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	266	0		20.00
21.00	INTRAVENOUS THERAPY	64.00	0	362,251	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	348,618	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	16,376	0		23.00
24.00	CLINICAL NUTRITION	66.01	0	43	0		24.00
25.00	OCCUPATIONAL THERAPY	67.00	0	22,327	0		25.00
26.00	SPEECH PATHOLOGY	68.00	0	907	0		26.00
27.00	ELECTROCARDIOLOGY	69.00	0	988,885	0		27.00
28.00	CARDIAC REHABILITATION	69.01	0	2,664	0		28.00
29.00	ELECTROENCEPHALOGRAPHY	70.00	0	53,469	0		29.00
30.00	ELECTROSHOCK THERAPY	70.01	0	12,390	0		30.00
31.00	RENAL DIALYSIS	74.00	0	43,844	0		31.00
32.00	ENDOSCOPY	76.00	0	668,751	0		32.00
33.00	CLINIC	90.00	0	102,921	0		33.00
34.00	EMERGENCY	91.00	0	1,285,266	0		34.00
	TOTALS		0	48,732,970			
	D - BHM - DEPT						
1.00		0.00	0	0	0		1.00
2.00	SUBPROVIDER - IPF	40.00	1,423,462	970,445	0		2.00
	TOTALS		1,423,462	970,445			

RECLASSIFICATIONS

Provider CCN: 26-0104

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

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	E - BHM - ADMIN						
1.00	SUBPROVIDER - IPF	40.00	3,208,199	1,090,029	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		3,208,199	1,090,029			
	F - PARKING GARAGE						
1.00		0.00	0	0	0		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	52,919	9		2.00
	TOTALS		0	52,919			
	G - CENTRAL DISTRIBUTION						
1.00	ADMINISTRATIVE & GENERAL	5.00	352,672	792,284	0		1.00
	TOTALS		352,672	792,284			
	H - RESIDENCY ANCILLARY						
1.00		0.00	0	0	0		1.00
2.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	79,047	0		2.00
	TOTALS		0	79,047			
	I - PHARMACY RESIDENCY						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY RESIDENCY PRGM	23.00	23,526	0	0		2.00
	TOTALS		23,526	0			
	J - DIETARY						
1.00	DIETARY	10.00	1,763,512	3,536,254	0		1.00
	TOTALS		1,763,512	3,536,254			
500.00	Grand Total: Decreases		11,732,203	99,670,248			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,615,392	0	0	0	0	1.00	
2.00	Land Improvements	2,865,359	151,469	0	151,469	25,395	2.00	
3.00	Buildings and Fixtures	116,346,200	16,695,962	0	16,695,962	1,613,555	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	3,739,894	417,645	0	417,645	30,779	5.00	
6.00	Movable Equipment	85,975,931	10,167,201	8,414	10,175,615	2,902,220	6.00	
7.00	HIT designated Assets	1,084,184	96,661	0	96,661	7,581	7.00	
8.00	Subtotal (sum of lines 1-7)	219,626,960	27,528,938	8,414	27,537,352	4,579,530	8.00	
9.00	Reconciling Items	13,523,721	7,590,870	0	7,590,870	28,251	9.00	
10.00	Total (line 8 minus line 9)	206,103,239	19,938,068	8,414	19,946,482	4,551,279	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,615,392	0				1.00	
2.00	Land Improvements	2,991,433	0				2.00	
3.00	Buildings and Fixtures	131,428,607	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	4,126,760	0				5.00	
6.00	Movable Equipment	93,249,326	0				6.00	
7.00	HIT designated Assets	1,173,264	0				7.00	
8.00	Subtotal (sum of lines 1-7)	242,584,782	0				8.00	
9.00	Reconciling Items	21,086,340	0				9.00	
10.00	Total (line 8 minus line 9)	221,498,442	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,552,849	0	1,548,464	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,730,873	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,283,722	0	1,548,464	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	8,101,313				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,730,873				2.00
3.00	Total (sum of lines 1-2)	0	14,832,186				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	144,035,432	0	144,035,432	0.593753	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	98,549,350	0	98,549,350	0.406247	0	2.00
3.00	Total (sum of lines 1-2)	242,584,782	0	242,584,782	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	6,994,966	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,953,523	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,948,489	0	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	1,201,706	0	0	0	8,196,672	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-266,349	0	0	0	8,687,174	2.00
3.00	Total (sum of lines 1-2)	935,357	0	0	0	16,883,846	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		A	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-346,758	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-18,316,646			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	12,871,465			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	BAD DEBT	A	-5,038	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	BAD DEBT	A	-102,376	SKILLED NURSING FACILITY	44.00	0	33.01
33.02	GIFT	A	-7,784	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	GIFT	A	-631,216	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	GIFT	A	-2,464	DIETARY	10.00	0	33.04
33.05	GIFT	A	-4,941	NURSING ADMINISTRATION	13.00	0	33.05
33.06	GIFT	A	-354	PHARMACY	15.00	0	33.06
33.07	GIFT	A	0	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	33.07
33.08	GIFT	A	-2,482	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	GIFT	A	0	INTENSIVE CARE UNIT	31.00	0	33.09
33.10	GIFT	A	-20	SUBPROVIDER - IPF	40.00	0	33.10
33.11	GIFT	A	-3,476	SKILLED NURSING FACILITY	44.00	0	33.11
33.12	GIFT	A	-280	OPERATING ROOM	50.00	0	33.12
33.13	GIFT	A	-11	RECOVERY ROOM	51.00	0	33.13
33.14	GIFT	A	-7,827	DELIVERY ROOM & LABOR ROOM	52.00	0	33.14
33.15	GIFT	A	-3,021	RADIOLOGY-DIAGNOSTIC	54.00	0	33.15
33.16	GIFT	A	-472	LABORATORY	60.00	0	33.16
33.17	GIFT	A	-621	RESPIRATORY THERAPY	65.00	0	33.17
33.18	GIFT	A	-100	ELECTROCARDIOLOGY	69.00	0	33.18
33.19	GIFT	A	0	ELECTROENCEPHALOGRAPHY	70.00	0	33.19
33.20	GIFT	A	0	ENDOSCOPY	76.00	0	33.20
33.21	GIFT	A	-2,012	CLINIC	90.00	0	33.21
33.22	GIFT	A	-889	EMERGENCY	91.00	0	33.22
33.23	PHONE	A	-52,196	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.27	PHONE	A	-5,427	SKILLED NURSING FACILITY	44.00	0	33.27
33.31	ENTERTAINMENT	A	-34,715	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	ENTERTAINMENT	A	-804	HOUSEKEEPING	9.00	0	33.32
33.33	ENTERTAINMENT	A	-341	ADULTS & PEDIATRICS	30.00	0	33.33
33.34	ENTERTAINMENT	A	-248	SKILLED NURSING FACILITY	44.00	0	33.34
33.35	ENTERTAINMENT	A	-112	DELIVERY ROOM & LABOR ROOM	52.00	0	33.35
33.36	ENTERTAINMENT	A	-424	EMERGENCY	91.00	0	33.36
33.37	NURSE PRACTITIONER	A	-356,014	ADULTS & PEDIATRICS	30.00	0	33.37
33.38	NURSE PRACTITIONER	A	-135,428	SUBPROVIDER - IPF	40.00	0	33.38
33.39	NURSE PRACTITIONER	A	-138,329	PERINATAL CLINIC	52.01	0	33.39
33.40	NON-MEDICAL TRANSPORT	A	-70,029	SOCIAL SERVICE	17.00	0	33.40
33.42	NON-MEDICAL TRANSPORT	A	-126,183	SUBPROVIDER - IPF	40.00	0	33.42
33.43	NON-MEDICAL TRANSPORT	A	-397	SKILLED NURSING FACILITY	44.00	0	33.43
33.44	NON-MEDICAL TRANSPORT	A	-94,928	CLINIC	90.00	0	33.44
33.45	NON-MEDICAL TRANSPORT	A	-820	EMERGENCY	91.00	0	33.45
33.46	MARKETING	A	-10,443	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	MARKETING	A	-1,275	NURSING ADMINISTRATION	13.00	0	33.47
33.48	MARKETING	A	-150	MEDICAL RECORDS & LIBRARY	16.00	0	33.48
33.49	MARKETING	A	-26,002	SKILLED NURSING FACILITY	44.00	0	33.49
33.51	MARKETING	A	-1,581	CLINIC	90.00	0	33.51
33.52	MARKETING	A	-70	EMERGENCY	91.00	0	33.52
33.53	FRA	A	-81,213	ADMINISTRATIVE & GENERAL	5.00	0	33.53
33.54	INTEREST INCOME	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.54
33.55	MISCELLANEOUS REVENUE	B	-2,060,766	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56	MISCELLANEOUS REVENUE	B	-319,485	OPERATION OF PLANT	7.00	0	33.56
33.57	MISCELLANEOUS REVENUE	B	-647	HOUSEKEEPING	9.00	0	33.57
33.58	MISCELLANEOUS REVENUE	B	-289	DIETARY	10.00	0	33.58
33.59	MISCELLANEOUS REVENUE	B	-17,376	NURSING ADMINISTRATION	13.00	0	33.59
33.60	MISCELLANEOUS REVENUE	B	-3	CENTRAL SERVICES & SUPPLY	14.00	0	33.60
33.61	MISCELLANEOUS REVENUE	B	-10,265	PHARMACY	15.00	0	33.61
33.62	MISCELLANEOUS REVENUE	B	-1,620	MEDICAL RECORDS & LIBRARY	16.00	0	33.62
33.63	MISCELLANEOUS REVENUE	B	-5	PHARMACY RESIDENCY PRGM	23.00	0	33.63
33.64	MISCELLANEOUS REVENUE	B	-20,375	ADULTS & PEDIATRICS	30.00	0	33.64
33.65	MISCELLANEOUS REVENUE	B	-380	INTENSIVE CARE UNIT	31.00	0	33.65
33.66	MISCELLANEOUS REVENUE	B	-670	SUBPROVIDER - IPF	40.00	0	33.66
33.67	MISCELLANEOUS REVENUE	B	0	NURSERY	43.00	0	33.67
33.68	MISCELLANEOUS REVENUE	B	-424	SKILLED NURSING FACILITY	44.00	0	33.68
33.69	MISCELLANEOUS REVENUE	B	-434	OPERATING ROOM	50.00	0	33.69
33.70	MISCELLANEOUS REVENUE	B	-46	RECOVERY ROOM	51.00	0	33.70
33.71	MISCELLANEOUS REVENUE	B	-2,272	DELIVERY ROOM & LABOR ROOM	52.00	0	33.71
33.72	MISCELLANEOUS REVENUE	B	-5,376	PERINATAL CLINIC	52.01	0	33.72
33.73	MISCELLANEOUS REVENUE	B	-16,156	ANESTHESIOLOGY	53.00	0	33.73
33.74	MISCELLANEOUS REVENUE	B	-467,701	RADIOLOGY-DIAGNOSTIC	54.00	0	33.74
33.75	MISCELLANEOUS REVENUE	B	-29,024	RADIOLOGY-THERAPEUTIC	55.00	0	33.75
33.76	MISCELLANEOUS REVENUE	B	-3,094	RADIOISOTOPE	56.00	0	33.76

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.77	MISCELLANEOUS REVENUE	B	-94,843	CT SCAN	57.00	0	33.77
33.78	MISCELLANEOUS REVENUE	B	-27,087	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.78
33.79	MISCELLANEOUS REVENUE	B	-14,164	CARDIAC CATHETERIZATION	59.00	0	33.79
33.80	MISCELLANEOUS REVENUE	B	-1,858,037	LABORATORY	60.00	0	33.80
33.81	MISCELLANEOUS REVENUE	B	-65,663	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	33.81
33.82	MISCELLANEOUS REVENUE	B	-83,625	INTRAVENOUS THERAPY	64.00	0	33.82
33.83	MISCELLANEOUS REVENUE	B	-2,961	RESPIRATORY THERAPY	65.00	0	33.83
33.84	MISCELLANEOUS REVENUE	B	-56	PHYSICAL THERAPY	66.00	0	33.84
33.85	MISCELLANEOUS REVENUE	B	-74,291	CLINICAL NUTRITION	66.01	0	33.85
33.86	MISCELLANEOUS REVENUE	B	0	OCCUPATIONAL THERAPY	67.00	0	33.86
33.87	MISCELLANEOUS REVENUE	B	-74	SPEECH PATHOLOGY	68.00	0	33.87
33.88	MISCELLANEOUS REVENUE	B	-28,097	ELECTROCARDIOLOGY	69.00	0	33.88
33.89	MISCELLANEOUS REVENUE	B	-26,175	CARDIAC REHABILITATION	69.01	0	33.89
33.90	MISCELLANEOUS REVENUE	B	-13	ELECTROENCEPHALOGRAPHY	70.00	0	33.90
33.91	MISCELLANEOUS REVENUE	B	-1,764,282	CAFETERIA	11.00	0	33.91
33.92	MISCELLANEOUS REVENUE	B	-3,713	ENDOSCOPY	76.00	0	33.92
33.93	MISCELLANEOUS REVENUE	B	-637,858	CLINIC	90.00	0	33.93
33.94	MISCELLANEOUS REVENUE	B	-25,445	EMERGENCY	91.00	0	33.94
33.95	LOBBYING	A	-34,904	ADMINISTRATIVE & GENERAL	5.00	0	33.95
33.96	LOBBYING	A	0	EMERGENCY	91.00	0	33.96
33.97	MISC MD COMPENSATION	A	-534,541	CLINIC	90.00	0	33.97
33.98	PHYSICIAN BENEFITS	A	-608,757	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.98
33.99	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.99
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,545,446				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: 26-0104

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 1:44 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	495,036	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,222,650	0
3.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	0	270,110
4.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	48,925,311	24,027,460
4.01		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	30,911,943	41,582,117
4.02		7.00	OPERATION OF PLANT	HOME OFFICE	0	914,028
4.03		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-2,002,163	0
4.04		2.00	CAP REL COSTS-MVBLE EQUIP	NETWORK--CORP 130 - INTEREST	3,761	0
4.05		5.00	ADMINISTRATIVE & GENERAL	NETWORK--CORP 130	8,778,029	9,419,430
4.06		13.00	NURSING ADMINISTRATION	NETWORK--CORP 130	206,157	221,221
4.07		30.00	ADULTS & PEDIATRICS	NETWORK--CORP 130	533,969	572,986
4.08		40.00	SUBPROVIDER - IPF	NETWORK--CORP 130	2,476,902	2,657,887
4.09		55.00	RADIOLOGY-THERAPEUTIC	NETWORK--CORP 130	203,962	218,865
4.10		70.00	ELECTROENCEPHALOGRAPHY	NETWORK--CORP 130	-167	-179
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		92,755,390	79,883,925

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

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

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

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

6.00	G	SSM HEALTH	100.00	FRAN SISTERS SM	100.00	6.00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS SM	100.00	7.00
8.00	G	SSM HEALTH	100.00	FRAN SISTERS SM	100.00	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:	CHURCH				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: 26-0104

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 1:44 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	495,036	9		1.00
2.00	2,222,650	9		2.00
3.00	-270,110	11		3.00
4.00	24,897,851	0		4.00
4.01	-10,670,174	0		4.01
4.02	-914,028	0		4.02
4.03	-2,002,163	0		4.03
4.04	3,761	11		4.04
4.05	-641,401	0		4.05
4.06	-15,064	0		4.06
4.07	-39,017	0		4.07
4.08	-180,985	0		4.08
4.09	-14,903	0		4.09
4.10	12	0		4.10
5.00	12,871,465			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	HOME OFFICE	6.00
7.00	STL NETWORK	7.00
8.00	SSM HOSPITALS	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: 26-0104

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

Worksheet A-8-2

Date/Time Prepared:
8/27/2020 1:44 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	522,363	9,739	512,624	211,500	3,501	1.00
2.00	15.00	PHARMACY	4,346	4,346	0	211,500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	8,026,569	7,727,843	298,726	197,500	2,557	3.00
4.00	31.00	INTENSIVE CARE UNIT	1,779,630	1,779,630	0	211,500	0	4.00
5.00	40.00	SUBPROVIDER - IPF	1,051,996	976,278	75,718	181,300	520	5.00
6.00	50.00	OPERATING ROOM	72,564	20,986	51,578	246,400	290	6.00
7.00	52.01	PERINATAL CLINIC	461,273	461,273	0	237,100	0	7.00
8.00	53.00	ANESTHESIOLOGY	3,180,373	3,090,656	89,717	239,400	487	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	271,900	0	9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	43,079	0	43,079	271,900	301	10.00
11.00	59.00	CARDIAC CATHETERIZATION	29,627	0	29,627	211,500	129	11.00
12.00	60.00	LABORATORY	267,557	256,417	11,140	260,300	111	12.00
13.00	64.00	INTRAVENOUS THERAPY	24,115	22,715	1,400	211,500	10	13.00
14.00	65.00	RESPIRATORY THERAPY	19,500	0	19,500	211,500	130	14.00
15.00	69.00	ELECTROCARDIOLOGY	384,893	384,893	0	211,500	0	15.00
16.00	69.01	CARDIAC REHABILITATION	8,973	0	8,973	211,500	39	16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	128,541	0	128,541	211,500	687	17.00
18.00	74.00	RENAL DIALYSIS	1,353	1,353	0	211,500	0	18.00
19.00	90.00	CLINIC	1,103,040	1,101,840	1,200	197,500	12	19.00
20.00	91.00	EMERGENCY	2,094,169	2,094,169	0	197,500	0	20.00
200.00			19,203,961	17,932,138	1,271,823		8,774	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	355,991	17,800	0	0	0	1.00
2.00	15.00	PHARMACY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	242,792	12,140	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	45,325	2,266	0	0	0	5.00
6.00	50.00	OPERATING ROOM	34,354	1,718	0	0	0	6.00
7.00	52.01	PERINATAL CLINIC	0	0	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	56,052	2,803	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	39,347	1,967	0	0	0	10.00
11.00	59.00	CARDIAC CATHETERIZATION	13,117	656	0	0	0	11.00
12.00	60.00	LABORATORY	13,891	695	0	0	0	12.00
13.00	64.00	INTRAVENOUS THERAPY	1,017	51	0	0	0	13.00
14.00	65.00	RESPIRATORY THERAPY	13,219	661	0	0	0	14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	15.00
16.00	69.01	CARDIAC REHABILITATION	3,966	198	0	0	0	16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	69,856	3,493	0	0	0	17.00
18.00	74.00	RENAL DIALYSIS	0	0	0	0	0	18.00
19.00	90.00	CLINIC	1,139	57	0	0	0	19.00
20.00	91.00	EMERGENCY	0	0	0	0	0	20.00
200.00			890,066	44,505	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	355,991	156,633	166,372		1.00
2.00	15.00	PHARMACY	0	0	0	4,346		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	242,792	55,934	7,783,777		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,779,630		4.00
5.00	40.00	SUBPROVIDER - IPF	0	45,325	30,393	1,006,671		5.00
6.00	50.00	OPERATING ROOM	0	34,354	17,224	38,210		6.00
7.00	52.01	PERINATAL CLINIC	0	0	0	461,273		7.00
8.00	53.00	ANESTHESIOLOGY	0	56,052	33,665	3,124,321		8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	0	39,347	3,732	3,732		10.00
11.00	59.00	CARDIAC CATHETERIZATION	0	13,117	16,510	16,510		11.00
12.00	60.00	LABORATORY	0	13,891	0	256,417		12.00
13.00	64.00	INTRAVENOUS THERAPY	0	1,017	383	23,098		13.00
14.00	65.00	RESPIRATORY THERAPY	0	13,219	6,281	6,281		14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	384,893		15.00
16.00	69.01	CARDIAC REHABILITATION	0	3,966	5,007	5,007		16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	0	69,856	58,685	58,685		17.00
18.00	74.00	RENAL DIALYSIS	0	0	0	1,353		18.00
19.00	90.00	CLINIC	0	1,139	61	1,101,901		19.00
20.00	91.00	EMERGENCY	0	0	0	2,094,169		20.00
200.00			0	890,066	384,508	18,316,646		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,196,672	8,196,672				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	8,687,174		8,687,174			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	56,905,844	32,718	34,676	56,973,238		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	78,759,233	1,319,260	1,398,207	4,594,765	86,071,465	5.00
7.00	00700	OPERATION OF PLANT	10,073,035	716,717	759,606	794,353	12,343,711	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	798,623	24,648	26,123	63,655	913,049	8.00
9.00	00900	HOUSEKEEPING	4,342,504	19,152	20,298	1,264,737	5,646,691	9.00
10.00	01000	DIETARY	2,598,420	194,844	206,504	407,682	3,407,450	10.00
11.00	01100	CAFETERIA	3,535,484	0	0	829,782	4,365,266	11.00
13.00	01300	NURSING ADMINISTRATION	3,425,786	74,101	78,535	1,160,661	4,739,083	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,553,882	216,101	229,033	333,754	3,332,770	14.00
15.00	01500	PHARMACY	7,462,105	31,946	33,858	2,578,851	10,106,760	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	615,106	49,341	52,293	193,077	909,817	16.00
17.00	01700	SOCIAL SERVICE	590,324	13,432	14,236	194,021	812,013	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,046,809	0	0	492,553	1,539,362	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	79,047	13,477	14,283	0	106,807	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	380,005	6,022	6,382	168,599	561,008	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,519,648	1,656,586	1,755,718	16,876,876	56,808,828	30.00
31.00	03100	INTENSIVE CARE UNIT	8,589,490	238,633	252,913	3,763,002	12,844,038	31.00
40.00	04000	SUBPROVIDER - IPF	-41,680	360,026	381,571	644,141	1,344,058	40.00
43.00	04300	NURSERY	1,813,940	79,362	84,111	795,571	2,772,984	43.00
44.00	04400	SKILLED NURSING FACILITY	3,989,687	0	0	0	3,989,687	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,157,958	678,838	719,461	3,905,344	19,461,601	50.00
51.00	05100	RECOVERY ROOM	1,062,387	0	0	429,337	1,491,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,226,699	378,070	400,694	1,002,225	4,007,688	52.00
52.01	05201	PERINATAL CLINIC	706,450	171,025	181,259	323,513	1,382,247	52.01
53.00	05300	ANESTHESIOLOGY	661,420	10,018	10,618	37,339	719,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,650,423	136,963	145,159	1,609,273	9,541,818	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,163,826	128,299	135,977	1,067,692	4,495,794	55.00
56.00	05600	RADIOISOTOPE	1,189,498	17,036	18,056	117,482	1,342,072	56.00
57.00	05700	CT SCAN	1,264,568	134,724	142,786	412,459	1,954,537	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	422,214	31,151	33,016	158,107	644,488	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,843,339	86,884	92,083	658,722	2,681,028	59.00
60.00	06000	LABORATORY	3,119,188	253,028	268,170	973,098	4,613,484	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,881,976	9,302	9,858	198,866	3,100,002	62.00
64.00	06400	INTRAVENOUS THERAPY	2,443,128	43,789	46,409	909,124	3,442,450	64.00
65.00	06500	RESPIRATORY THERAPY	3,433,722	90,756	96,187	1,177,523	4,798,188	65.00
66.00	06600	PHYSICAL THERAPY	2,373,328	89,413	94,764	0	2,557,505	66.00
66.01	06601	CLINICAL NUTRITION	634,956	0	0	332,539	967,495	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,019,095	47,740	50,597	0	1,117,432	67.00
68.00	06800	SPEECH PATHOLOGY	488,703	1,108	1,174	0	490,985	68.00
69.00	06900	ELECTROCARDIOLOGY	3,742,627	10,925	11,579	1,376,879	5,142,010	69.00
69.01	06901	CARDIAC REHABILITATION	278,062	106,674	113,057	141,635	639,428	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	317,215	7,701	8,162	143,295	476,373	70.00
70.01	07001	ELECTROSHOCK THERAPY	105,160	17,350	18,388	48,557	189,455	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,087,938	0	0	0	27,087,938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,642,869	0	0	0	19,642,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,055,786	0	0	0	41,055,786	73.00
74.00	07400	RENAL DIALYSIS	1,860,237	16,589	17,581	8	1,894,415	74.00
76.00	03330	ENDOSCOPY	1,234,890	46,184	48,948	439,447	1,769,469	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,419,602	291,914	309,383	2,442,648	10,463,547	90.00
91.00	09100	EMERGENCY	10,208,037	310,618	329,206	3,801,891	14,649,752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	404,616,439	8,162,465	8,650,919	56,863,083	404,435,822	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	118,520	18,861	19,990	21,920	179,291	190.00
191.00	19100	RESEARCH	91,875	0	0	43,230	135,105	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,563	12,255	0	23,818	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	106,103	3,783	4,010	45,005	158,901	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	17,756,662	0	0	0	17,756,662	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
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)	422,689,599	8,196,672	8,687,174	56,973,238	422,689,599	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	86,071,465					5.00
7.00	00700	OPERATION OF PLANT	3,156,225	15,499,936				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	233,462	62,344	1,208,855			8.00
9.00	00900	HOUSEKEEPING	1,443,831	48,443	0	7,138,965		9.00
10.00	01000	DIETARY	871,268	492,834	0	228,624	5,000,176	10.00
11.00	01100	CAFETERIA	1,116,177	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,211,760	187,428	0	86,947	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	852,173	546,599	0	253,565	0	14.00
15.00	01500	PHARMACY	2,584,248	80,804	0	37,484	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	232,636	124,801	0	57,895	0	16.00
17.00	01700	SOCIAL SERVICE	207,628	33,975	0	15,761	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	393,607	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	27,310	34,088	0	15,813	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	143,447	15,232	0	7,066	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,525,625	4,190,122	958,557	1,943,782	3,964,871	30.00
31.00	03100	INTENSIVE CARE UNIT	3,284,156	603,592	180,233	280,004	745,495	31.00
40.00	04000	SUBPROVIDER - IPF	343,669	910,640	70,065	422,442	289,810	40.00
43.00	04300	NURSERY	709,038	200,735	0	93,120	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,020,143	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,976,234	1,717,034	0	796,525	0	50.00
51.00	05100	RECOVERY ROOM	381,426	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,024,746	956,280	0	443,614	0	52.00
52.01	05201	PERINATAL CLINIC	353,434	432,585	0	200,675	0	52.01
53.00	05300	ANESTHESIOLOGY	183,946	25,340	0	11,755	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,439,795	346,431	0	160,708	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,149,552	324,517	0	150,542	0	55.00
56.00	05600	RADIOISOTOPE	343,161	43,091	0	19,990	0	56.00
57.00	05700	CT SCAN	499,765	340,768	0	158,081	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	164,792	78,793	0	36,552	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	685,525	219,761	0	101,946	0	59.00
60.00	06000	LABORATORY	1,179,645	640,002	0	296,894	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	792,655	23,528	0	10,914	0	62.00
64.00	06400	INTRAVENOUS THERAPY	880,217	110,758	0	51,380	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,226,873	229,557	0	106,491	0	65.00
66.00	06600	PHYSICAL THERAPY	653,941	226,159	0	104,914	0	66.00
66.01	06601	CLINICAL NUTRITION	247,384	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	285,722	120,752	0	56,017	0	67.00
68.00	06800	SPEECH PATHOLOGY	125,542	2,803	0	1,300	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,314,786	27,633	0	12,819	0	69.00
69.01	06901	CARDIAC REHABILITATION	163,499	269,817	0	125,167	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	121,806	19,479	0	9,036	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	48,443	43,884	0	20,358	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,926,250	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,022,583	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,497,759	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	484,392	41,959	0	19,465	0	74.00
76.00	03330	ENDOSCOPY	452,444	116,817	0	54,191	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,675,477	738,359	0	342,522	0	90.00
91.00	09100	EMERGENCY	3,745,868	785,669	0	364,469	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81,404,065	15,413,413	1,208,855	7,098,828	5,000,176	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,844	47,706	0	22,131	0	190.00
191.00	19100	RESEARCH	34,546	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,090	29,247	0	13,567	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	40,630	9,570	0	4,439	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	4,540,290	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,071,465	15,499,936	1,208,855	7,138,965	5,000,176	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	5,481,443					11.00
13.00	01300	NURSING ADMINISTRATION	129,791	6,355,009				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,322	0	5,022,429			14.00
15.00	01500	PHARMACY	288,381	0	0	13,097,677		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,591	0	0	0	1,346,740	16.00
17.00	01700	SOCIAL SERVICE	21,697	0	0	1,602	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	55,080	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	18,854	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,887,222	3,016,372	0	238	137,144	30.00
31.00	03100	INTENSIVE CARE UNIT	420,799	604,868	0	66	40,326	31.00
40.00	04000	SUBPROVIDER - IPF	72,031	389,204	0	435	6,872	40.00
43.00	04300	NURSERY	88,965	106,410	0	0	2,379	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	436,717	466,060	0	251	128,693	50.00
51.00	05100	RECOVERY ROOM	48,011	62,289	0	0	11,506	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	112,074	218,785	0	13	12,441	52.00
52.01	05201	PERINATAL CLINIC	36,177	19,142	0	0	5,917	52.01
53.00	05300	ANESTHESIOLOGY	4,175	13,824	0	0	33,625	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,958	82,170	0	1,772	72,017	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	119,395	11,179	0	0	42,156	55.00
56.00	05600	RADIOISOTOPE	13,137	4	0	179	7,898	56.00
57.00	05700	CT SCAN	46,123	35	0	0	67,467	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,680	7	0	0	17,664	58.00
59.00	05900	CARDIAC CATHETERIZATION	73,662	80,891	0	0	45,699	59.00
60.00	06000	LABORATORY	108,817	21	0	0	82,005	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,238	0	0	341,905	10,039	62.00
64.00	06400	INTRAVENOUS THERAPY	101,663	136,528	0	355	16,760	64.00
65.00	06500	RESPIRATORY THERAPY	131,677	11	0	250	26,081	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	6,738	66.00
66.01	06601	CLINICAL NUTRITION	37,186	0	0	0	158	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3,460	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,385	68.00
69.00	06900	ELECTROCARDIOLOGY	153,970	190,959	0	0	69,402	69.00
69.01	06901	CARDIAC REHABILITATION	15,838	20,838	0	53	804	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	16,024	4,043	0	0	7,099	70.00
70.01	07001	ELECTROSHOCK THERAPY	5,430	8,975	0	0	830	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,004,133	0	21,783	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,018,296	0	35,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,331,509	289,358	73.00
74.00	07400	RENAL DIALYSIS	1	0	0	0	5,567	74.00
76.00	03330	ENDOSCOPY	49,141	75,689	0	2	15,798	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	273,150	213,128	0	418,965	23,420	90.00
91.00	09100	EMERGENCY	425,148	626,858	0	82	97,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,469,125	6,348,290	5,022,429	13,097,677	1,346,740	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,451	0	0	0	0	190.00
191.00	19100	RESEARCH	4,834	6,551	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	5,033	168	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,481,443	6,355,009	5,022,429	13,097,677	1,346,740	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
				SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS		
		17.00	19.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	1,092,676				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,988,049			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		184,018		22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0			745,607	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	866,434	0	1,347,720	124,747	30.00
31.00	03100	INTENSIVE CARE UNIT	162,911	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	63,331	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	525,676	48,658	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	10,816	1,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	34,612	3,204	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	17,306	1,602	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	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	51,919	4,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				196,212	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,092,676	0	1,988,049	184,018	745,607
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,092,676	0	1,988,049	184,018	745,607

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PHARMACY RESIDENCY PRGM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,007,117	-1,472,467	88,534,650	30.00
31.00	03100	INTENSIVE CARE UNIT	19,244,973	0	19,244,973	31.00
40.00	04000	SUBPROVIDER - IPF	4,069,527	0	4,069,527	40.00
43.00	04300	NURSERY	3,973,631	0	3,973,631	43.00
44.00	04400	SKILLED NURSING FACILITY	5,009,830	0	5,009,830	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,557,449	-574,334	27,983,115	50.00
51.00	05100	RECOVERY ROOM	1,994,956	0	1,994,956	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,775,641	0	6,775,641	52.00
52.01	05201	PERINATAL CLINIC	2,430,177	0	2,430,177	52.01
53.00	05300	ANESTHESIOLOGY	1,003,877	-11,817	992,060	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,862,485	-37,816	12,824,669	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,293,135	0	6,293,135	55.00
56.00	05600	RADIOISOTOPE	1,769,532	0	1,769,532	56.00
57.00	05700	CT SCAN	3,066,776	0	3,066,776	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	959,976	0	959,976	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,907,420	-18,908	3,888,512	59.00
60.00	06000	LABORATORY	6,920,868	0	6,920,868	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,301,281	0	4,301,281	62.00
64.00	06400	INTRAVENOUS THERAPY	4,740,111	0	4,740,111	64.00
65.00	06500	RESPIRATORY THERAPY	6,519,128	0	6,519,128	65.00
66.00	06600	PHYSICAL THERAPY	3,549,257	0	3,549,257	66.00
66.01	06601	CLINICAL NUTRITION	1,252,223	0	1,252,223	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,583,383	0	1,583,383	67.00
68.00	06800	SPEECH PATHOLOGY	623,015	0	623,015	68.00
69.00	06900	ELECTROCARDIOLOGY	6,990,064	0	6,990,064	69.00
69.01	06901	CARDIAC REHABILITATION	1,235,444	0	1,235,444	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	653,860	0	653,860	70.00
70.01	07001	ELECTROSHOCK THERAPY	317,375	0	317,375	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,040,104	0	37,040,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,719,009	0	26,719,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,174,412	0	64,174,412	73.00
74.00	07400	RENAL DIALYSIS	2,445,799	0	2,445,799	74.00
76.00	03330	ENDOSCOPY	2,533,551	0	2,533,551	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,148,568	0	15,148,568	90.00
91.00	09100	EMERGENCY	20,948,771	-56,725	20,892,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	399,622,725	-2,172,067	397,450,658	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	297,423	0	297,423	190.00
191.00	19100	RESEARCH	181,036	0	181,036	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,722	0	72,722	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	218,741	0	218,741	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	22,296,952	0	22,296,952	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	422,689,599	-2,172,067	420,517,532		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	32,718	34,676	67,394	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,032,097	1,319,260	1,398,207	3,749,564	5.00
7.00	00700	OPERATION OF PLANT	0	716,717	759,606	1,476,323	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,648	26,123	50,771	8.00
9.00	00900	HOUSEKEEPING	2,864	19,152	20,298	42,314	9.00
10.00	01000	DIETARY	28,854	194,844	206,504	430,202	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	74,101	78,535	152,636	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	94,733	216,101	229,033	539,867	14.00
15.00	01500	PHARMACY	512,911	31,946	33,858	578,715	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,341	52,293	101,634	16.00
17.00	01700	SOCIAL SERVICE	0	13,432	14,236	27,668	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	4,871	0	0	4,871	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	13,477	14,283	27,760	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0	6,022	6,382	12,404	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,656,586	1,755,718	3,412,304	30.00
31.00	03100	INTENSIVE CARE UNIT	170	238,633	252,913	491,716	31.00
40.00	04000	SUBPROVIDER - IPF	0	360,026	381,571	741,597	40.00
43.00	04300	NURSERY	0	79,362	84,111	163,473	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,536,687	678,838	719,461	2,934,986	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	378,070	400,694	778,764	52.00
52.01	05201	PERINATAL CLINIC	118,980	171,025	181,259	471,264	52.01
53.00	05300	ANESTHESIOLOGY	110,211	10,018	10,618	130,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	242,705	136,963	145,159	524,827	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	703,278	128,299	135,977	967,554	55.00
56.00	05600	RADIOISOTOPE	0	17,036	18,056	35,092	56.00
57.00	05700	CT SCAN	25,660	134,724	142,786	303,170	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	31,151	33,016	64,167	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	86,884	92,083	178,967	59.00
60.00	06000	LABORATORY	105,606	253,028	268,170	626,804	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9,302	9,858	19,160	62.00
64.00	06400	INTRAVENOUS THERAPY	278,814	43,789	46,409	369,012	64.00
65.00	06500	RESPIRATORY THERAPY	133,762	90,756	96,187	320,705	65.00
66.00	06600	PHYSICAL THERAPY	0	89,413	94,764	184,177	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	47,740	50,597	98,337	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,108	1,174	2,282	68.00
69.00	06900	ELECTROCARDIOLOGY	369,742	10,925	11,579	392,246	69.00
69.01	06901	CARDIAC REHABILITATION	0	106,674	113,057	219,731	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,701	8,162	15,863	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	17,350	18,388	35,738	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	16,589	17,581	34,170	74.00
76.00	03330	ENDOSCOPY	263,799	46,184	48,948	358,931	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,150,254	291,914	309,383	1,751,551	90.00
91.00	09100	EMERGENCY	145,314	310,618	329,206	785,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,861,312	8,162,465	8,650,919	23,674,696	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,861	19,990	38,851	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,563	12,255	23,818	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	3,783	4,010	7,793	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,861,312	8,196,672	8,687,174	23,745,158	67,394	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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	3,755,003					5.00
7.00	00700	OPERATION OF PLANT	137,694	1,614,957				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,185	6,496	67,527			8.00
9.00	00900	HOUSEKEEPING	62,989	5,047	0	111,847		9.00
10.00	01000	DIETARY	38,010	51,349	0	3,582	523,626	10.00
11.00	01100	CAFETERIA	48,695	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	52,864	19,528	0	1,362	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,177	56,951	0	3,973	0	14.00
15.00	01500	PHARMACY	112,741	8,419	0	587	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,149	13,003	0	907	0	16.00
17.00	01700	SOCIAL SERVICE	9,058	3,540	0	247	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	17,172	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,191	3,552	0	248	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	6,258	1,587	0	111	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	633,729	436,571	53,545	30,452	415,208	30.00
31.00	03100	INTENSIVE CARE UNIT	143,275	62,889	10,068	4,387	78,069	31.00
40.00	04000	SUBPROVIDER - IPF	14,993	94,881	3,914	6,618	30,349	40.00
43.00	04300	NURSERY	30,933	20,915	0	1,459	0	43.00
44.00	04400	SKILLED NURSING FACILITY	44,505	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	217,094	178,900	0	12,479	0	50.00
51.00	05100	RECOVERY ROOM	16,640	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,706	99,636	0	6,950	0	52.00
52.01	05201	PERINATAL CLINIC	15,419	45,072	0	3,144	0	52.01
53.00	05300	ANESTHESIOLOGY	8,025	2,640	0	184	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	106,439	36,095	0	2,518	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	50,151	33,812	0	2,359	0	55.00
56.00	05600	RADIOISOTOPE	14,971	4,490	0	313	0	56.00
57.00	05700	CT SCAN	21,803	35,505	0	2,477	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,189	8,210	0	573	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	29,907	22,897	0	1,597	0	59.00
60.00	06000	LABORATORY	51,463	66,683	0	4,651	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	34,581	2,451	0	171	0	62.00
64.00	06400	INTRAVENOUS THERAPY	38,401	11,540	0	805	0	64.00
65.00	06500	RESPIRATORY THERAPY	53,524	23,918	0	1,668	0	65.00
66.00	06600	PHYSICAL THERAPY	28,529	23,564	0	1,644	0	66.00
66.01	06601	CLINICAL NUTRITION	10,792	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	12,465	12,581	0	878	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,477	292	0	20	0	68.00
69.00	06900	ELECTROCARDIOLOGY	57,359	2,879	0	201	0	69.00
69.01	06901	CARDIAC REHABILITATION	7,133	28,113	0	1,961	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5,314	2,030	0	142	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	2,113	4,572	0	319	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	302,166	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,116	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	457,977	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,132	4,372	0	305	0	74.00
76.00	03330	ENDOSCOPY	19,738	12,171	0	849	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	116,721	76,931	0	5,366	0	90.00
91.00	09100	EMERGENCY	163,418	81,860	0	5,710	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,551,381	1,605,942	67,527	111,217	523,626	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,000	4,971	0	347	0	190.00
191.00	19100	RESEARCH	1,507	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	266	3,047	0	213	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	1,773	997	0	70	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	198,076	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,755,003	1,614,957	67,527	111,847	523,626	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	49,677					11.00
13.00	01300	NURSING ADMINISTRATION	1,177	228,941				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	338	0	638,701			14.00
15.00	01500	PHARMACY	2,614	0	0	706,129		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	196	0	0	0	126,118	16.00
17.00	01700	SOCIAL SERVICE	197	0	0	86	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	499	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	171	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,094	108,666	0	13	12,847	30.00
31.00	03100	INTENSIVE CARE UNIT	3,815	21,791	0	4	3,778	31.00
40.00	04000	SUBPROVIDER - IPF	653	14,021	0	23	644	40.00
43.00	04300	NURSERY	807	3,833	0	0	223	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,959	16,790	0	14	12,056	50.00
51.00	05100	RECOVERY ROOM	435	2,244	0	0	1,078	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,016	7,882	0	1	1,165	52.00
52.01	05201	PERINATAL CLINIC	328	690	0	0	554	52.01
53.00	05300	ANESTHESIOLOGY	38	498	0	0	3,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,631	2,960	0	96	6,746	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,082	403	0	0	3,949	55.00
56.00	05600	RADIOISOTOPE	119	0	0	10	740	56.00
57.00	05700	CT SCAN	418	1	0	0	6,320	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	160	0	0	0	1,655	58.00
59.00	05900	CARDIAC CATHETERIZATION	668	2,914	0	0	4,281	59.00
60.00	06000	LABORATORY	986	1	0	0	7,682	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	202	0	0	18,432	940	62.00
64.00	06400	INTRAVENOUS THERAPY	922	4,918	0	19	1,570	64.00
65.00	06500	RESPIRATORY THERAPY	1,194	0	0	13	2,443	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	631	66.00
66.01	06601	CLINICAL NUTRITION	337	0	0	0	15	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	324	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	223	68.00
69.00	06900	ELECTROCARDIOLOGY	1,396	6,879	0	0	6,501	69.00
69.01	06901	CARDIAC REHABILITATION	144	751	0	3	75	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	145	146	0	0	665	70.00
70.01	07001	ELECTROSHOCK THERAPY	49	323	0	0	78	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	382,043	0	2,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	256,658	0	3,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	664,824	27,066	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	522	74.00
76.00	03330	ENDOSCOPY	445	2,727	0	0	1,480	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,476	7,678	0	22,587	2,194	90.00
91.00	09100	EMERGENCY	3,854	22,583	0	4	9,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,565	228,699	638,701	706,129	126,118	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22	0	0	0	0	190.00
191.00	19100	RESEARCH	44	236	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	46	6	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	49,677	228,941	638,701	706,129	126,118	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
				SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS		
		17.00	19.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	41,026				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	23,125			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		32,751		22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0			20,731	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,531				30.00
31.00	03100	INTENSIVE CARE UNIT	6,117				31.00
40.00	04000	SUBPROVIDER - IPF	2,378				40.00
43.00	04300	NURSERY	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0				44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0				50.00
51.00	05100	RECOVERY ROOM	0				51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0				52.00
52.01	05201	PERINATAL CLINIC	0				52.01
53.00	05300	ANESTHESIOLOGY	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0				54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0				55.00
56.00	05600	RADIOISOTOPE	0				56.00
57.00	05700	CT SCAN	0				57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0				58.00
59.00	05900	CARDIAC CATHETERIZATION	0				59.00
60.00	06000	LABORATORY	0				60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0				62.00
64.00	06400	INTRAVENOUS THERAPY	0				64.00
65.00	06500	RESPIRATORY THERAPY	0				65.00
66.00	06600	PHYSICAL THERAPY	0				66.00
66.01	06601	CLINICAL NUTRITION	0				66.01
67.00	06700	OCCUPATIONAL THERAPY	0				67.00
68.00	06800	SPEECH PATHOLOGY	0				68.00
69.00	06900	ELECTROCARDIOLOGY	0				69.00
69.01	06901	CARDIAC REHABILITATION	0				69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0				70.00
70.01	07001	ELECTROSHOCK THERAPY	0				70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0				73.00
74.00	07400	RENAL DIALYSIS	0				74.00
76.00	03330	ENDOSCOPY	0				76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0				90.00
91.00	09100	EMERGENCY	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,026	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190.00
191.00	19100	RESEARCH	0				191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0				192.00
193.00	19300	NONPAID WORKERS	0				193.00
194.00	07951	NONREIMBURSABLE	0				194.00
194.01	07952	NONREIMBURSABLE	0				194.01
194.02	07953	NONREIMBURSABLE	0				194.02
194.03	07950	RETAIL PHARMACY	0				194.03
200.00		Cross Foot Adjustments		0	23,125	32,751	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,026	0	23,125	32,751	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PHARMACY RESIDENCY PRGM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,172,888	0	5,172,888	30.00
31.00	03100	INTENSIVE CARE UNIT	830,364	0	830,364	31.00
40.00	04000	SUBPROVIDER - IPF	910,834	0	910,834	40.00
43.00	04300	NURSERY	222,585	0	222,585	43.00
44.00	04400	SKILLED NURSING FACILITY	44,505	0	44,505	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,380,901	0	3,380,901	50.00
51.00	05100	RECOVERY ROOM	20,905	0	20,905	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	941,306	0	941,306	52.00
52.01	05201	PERINATAL CLINIC	536,854	0	536,854	52.01
53.00	05300	ANESTHESIOLOGY	145,426	0	145,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	683,217	0	683,217	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,060,574	0	1,060,574	55.00
56.00	05600	RADIOISOTOPE	55,874	0	55,874	56.00
57.00	05700	CT SCAN	370,182	0	370,182	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	82,141	0	82,141	58.00
59.00	05900	CARDIAC CATHETERIZATION	242,011	0	242,011	59.00
60.00	06000	LABORATORY	759,422	0	759,422	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	76,172	0	76,172	62.00
64.00	06400	INTRAVENOUS THERAPY	428,263	0	428,263	64.00
65.00	06500	RESPIRATORY THERAPY	404,859	0	404,859	65.00
66.00	06600	PHYSICAL THERAPY	238,545	0	238,545	66.00
66.01	06601	CLINICAL NUTRITION	11,538	0	11,538	66.01
67.00	06700	OCCUPATIONAL THERAPY	124,585	0	124,585	67.00
68.00	06800	SPEECH PATHOLOGY	8,294	0	8,294	68.00
69.00	06900	ELECTROCARDIOLOGY	469,091	0	469,091	69.00
69.01	06901	CARDIAC REHABILITATION	258,079	0	258,079	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	24,475	0	24,475	70.00
70.01	07001	ELECTROSHOCK THERAPY	43,249	0	43,249	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	686,250	0	686,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	479,077	0	479,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,149,867	0	1,149,867	73.00
74.00	07400	RENAL DIALYSIS	60,501	0	60,501	74.00
76.00	03330	ENDOSCOPY	396,861	0	396,861	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,988,396	0	1,988,396	90.00
91.00	09100	EMERGENCY	1,076,247	0	1,076,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,384,338	0	23,384,338	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,217	0	46,217	190.00
191.00	19100	RESEARCH	1,838	0	1,838	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,344	0	27,344	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	10,738	0	10,738	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	198,076	0	198,076	194.03
200.00		Cross Foot Adjustments	76,607	0	76,607	200.00
201.00		Negative Cost Centers	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	23,745,158	0	23,745,158		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	732,274					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		732,274				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,923	2,923	121,083,626			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	117,860	117,860	9,765,125	-86,071,465	336,618,134	5.00
7.00	00700	OPERATION OF PLANT	64,030	64,030	1,688,217	0	12,343,711	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	2,202	135,285	0	913,049	8.00
9.00	00900	HOUSEKEEPING	1,711	1,711	2,687,910	0	5,646,691	9.00
10.00	01000	DIETARY	17,407	17,407	866,435	0	3,407,450	10.00
11.00	01100	CAFETERIA	0	0	1,763,512	0	4,365,266	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	6,620	2,466,720	0	4,739,083	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	19,306	709,317	0	3,332,770	14.00
15.00	01500	PHARMACY	2,854	2,854	5,480,759	0	10,106,760	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	4,408	410,341	0	909,817	16.00
17.00	01700	SOCIAL SERVICE	1,200	1,200	412,348	0	812,013	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,046,809	0	1,539,362	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,204	1,204	0	0	106,807	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	538	538	358,318	0	561,008	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	147,996	147,996	35,867,959	0	56,808,828	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	21,319	7,997,402	0	12,844,038	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	32,164	1,368,975	0	1,344,058	40.00
43.00	04300	NURSERY	7,090	7,090	1,690,804	0	2,772,984	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	3,989,687	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,646	60,646	8,299,918	0	19,461,601	50.00
51.00	05100	RECOVERY ROOM	0	0	912,458	0	1,491,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,776	33,776	2,130,000	0	4,007,688	52.00
52.01	05201	PERINATAL CLINIC	15,279	15,279	687,553	0	1,382,247	52.01
53.00	05300	ANESTHESIOLOGY	895	895	79,355	0	719,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,236	12,236	3,420,142	0	9,541,818	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,462	11,462	2,269,137	0	4,495,794	55.00
56.00	05600	RADIOISOTOPE	1,522	1,522	249,681	0	1,342,072	56.00
57.00	05700	CT SCAN	12,036	12,036	876,587	0	1,954,537	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,783	2,783	336,020	0	644,488	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,762	7,762	1,399,963	0	2,681,028	59.00
60.00	06000	LABORATORY	22,605	22,605	2,068,098	0	4,613,484	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	831	831	422,644	0	3,100,002	62.00
64.00	06400	INTRAVENOUS THERAPY	3,912	3,912	1,932,135	0	3,442,450	64.00
65.00	06500	RESPIRATORY THERAPY	8,108	8,108	2,502,556	0	4,798,188	65.00
66.00	06600	PHYSICAL THERAPY	7,988	7,988	0	0	2,557,505	66.00
66.01	06601	CLINICAL NUTRITION	0	0	706,736	0	967,495	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,265	4,265	0	0	1,117,432	67.00
68.00	06800	SPEECH PATHOLOGY	99	99	0	0	490,985	68.00
69.00	06900	ELECTROCARDIOLOGY	976	976	2,926,243	0	5,142,010	69.00
69.01	06901	CARDIAC REHABILITATION	9,530	9,530	301,012	0	639,428	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	688	688	304,541	0	476,373	70.00
70.01	07001	ELECTROSHOCK THERAPY	1,550	1,550	103,197	0	189,455	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	27,087,938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,642,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	41,055,786	73.00
74.00	07400	RENAL DIALYSIS	1,482	1,482	18	0	1,894,415	74.00
76.00	03330	ENDOSCOPY	4,126	4,126	933,944	0	1,769,469	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	26,079	26,079	5,191,292	0	10,463,547	90.00
91.00	09100	EMERGENCY	27,750	27,750	8,080,052	0	14,649,752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	729,218	729,218	120,849,518	-86,071,465	318,364,357	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,685	1,685	46,586	0	179,291	190.00
191.00	19100	RESEARCH	0	0	91,875	0	135,105	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,033	1,033	0	0	23,818	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	338	338	95,647	0	158,901	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	17,756,662	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
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)	8,196,672	8,687,174	56,973,238		86,071,465	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.193449	11.863283	0.470528		0.255695	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			67,394		3,755,003	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000557		0.011155	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	547,461					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	103,606				8.00
9.00	00900	HOUSEKEEPING	1,711	0	543,548			9.00
10.00	01000	DIETARY	17,407	0	17,407	103,606		10.00
11.00	01100	CAFETERIA	0	0	0	0	104,177,142	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	0	6,620	0	2,466,720	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	0	19,306	0	709,317	14.00
15.00	01500	PHARMACY	2,854	0	2,854	0	5,480,759	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	0	4,408	0	410,341	16.00
17.00	01700	SOCIAL SERVICE	1,200	0	1,200	0	412,348	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,046,809	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,204	0	1,204	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	538	0	538	0	358,318	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	147,996	82,154	147,996	82,154	35,867,959	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	15,447	21,319	15,447	7,997,402	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	6,005	32,164	6,005	1,368,975	40.00
43.00	04300	NURSERY	7,090	0	7,090	0	1,690,804	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,646	0	60,646	0	8,299,918	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	912,458	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,776	0	33,776	0	2,130,000	52.00
52.01	05201	PERINATAL CLINIC	15,279	0	15,279	0	687,553	52.01
53.00	05300	ANESTHESIOLOGY	895	0	895	0	79,355	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,236	0	12,236	0	3,420,142	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,462	0	11,462	0	2,269,137	55.00
56.00	05600	RADIOISOTOPE	1,522	0	1,522	0	249,681	56.00
57.00	05700	CT SCAN	12,036	0	12,036	0	876,587	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,783	0	2,783	0	336,020	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,762	0	7,762	0	1,399,963	59.00
60.00	06000	LABORATORY	22,605	0	22,605	0	2,068,098	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	831	0	831	0	422,644	62.00
64.00	06400	INTRAVENOUS THERAPY	3,912	0	3,912	0	1,932,135	64.00
65.00	06500	RESPIRATORY THERAPY	8,108	0	8,108	0	2,502,556	65.00
66.00	06600	PHYSICAL THERAPY	7,988	0	7,988	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	706,736	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,265	0	4,265	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	99	0	99	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	976	0	976	0	2,926,243	69.00
69.01	06901	CARDIAC REHABILITATION	9,530	0	9,530	0	301,012	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	688	0	688	0	304,541	70.00
70.01	07001	ELECTROSHOCK THERAPY	1,550	0	1,550	0	103,197	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,482	0	1,482	0	18	74.00
76.00	03330	ENDOSCOPY	4,126	0	4,126	0	933,944	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	26,079	0	26,079	0	5,191,292	90.00
91.00	09100	EMERGENCY	27,750	0	27,750	0	8,080,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	544,405	103,606	540,492	103,606	103,943,034	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,685	0	1,685	0	46,586	190.00
191.00	19100	RESEARCH	0	0	0	0	91,875	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,033	0	1,033	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	338	0	338	0	95,647	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	15,499,936	1,208,855	7,138,965	5,000,176	5,481,443	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.312402	11.667809	13.134010	48.261452	0.052617	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,614,957	67,527	111,847	523,626	49,677	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.949903	0.651767	0.205772	5.054012	0.000477	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,814,000					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	48,881,165				14.00
15.00	01500	PHARMACY	0	0	43,202,936			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,576,098,092		16.00
17.00	01700	SOCIAL SERVICE	0	0	5,285	0	103,606	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	861,006	0	785	160,589,950	82,154	30.00
31.00	03100	INTENSIVE CARE UNIT	172,656	0	219	47,220,403	15,447	31.00
40.00	04000	SUBPROVIDER - IPF	111,096	0	1,436	8,046,729	6,005	40.00
43.00	04300	NURSERY	30,374	0	0	2,785,466	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	133,034	0	829	150,693,938	0	50.00
51.00	05100	RECOVERY ROOM	17,780	0	0	13,472,718	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	62,451	0	44	14,568,467	0	52.00
52.01	05201	PERINATAL CLINIC	5,464	0	0	6,929,049	0	52.01
53.00	05300	ANESTHESIOLOGY	3,946	0	0	39,373,697	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,455	0	5,846	84,329,207	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,191	0	0	49,362,614	0	55.00
56.00	05600	RADIOISOTOPE	1	0	592	9,248,403	0	56.00
57.00	05700	CT SCAN	10	0	0	79,001,174	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2	0	0	20,683,677	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,090	0	0	53,512,153	0	59.00
60.00	06000	LABORATORY	6	0	0	96,024,492	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1,127,782	11,754,779	0	62.00
64.00	06400	INTRAVENOUS THERAPY	38,971	0	1,170	19,624,782	0	64.00
65.00	06500	RESPIRATORY THERAPY	3	0	824	30,539,687	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,890,514	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	185,376	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,051,001	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,793,025	0	68.00
69.00	06900	ELECTROCARDIOLOGY	54,508	0	0	81,266,600	0	69.00
69.01	06901	CARDIAC REHABILITATION	5,948	0	176	940,958	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,154	0	0	8,313,160	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	2,562	0	0	972,272	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,238,003	0	25,506,659	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,643,162	0	41,288,981	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	40,675,707	337,945,717	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,519,004	0	74.00
76.00	03330	ENDOSCOPY	21,605	0	5	18,499,038	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	60,836	0	1,381,966	27,423,963	0	90.00
91.00	09100	EMERGENCY	178,933	0	270	114,740,439	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,812,082	48,881,165	43,202,936	1,576,098,092	103,606	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	1,870	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	48	0	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	6,355,009	5,022,429	13,097,677	1,346,740	1,092,676	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.503313	0.102748	0.303166	0.000854	10.546455	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	228,941	638,701	706,129	126,118	41,026	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.126208	0.013066	0.016344	0.000080	0.395981	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			INTERNS & RESIDENTS			PHARMACY RESIDENCY PRGM (ASSIGNED TIME)		
			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
			19.00	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		1,838				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			1,838			22.00
23.00	02300	PHARMACY RESIDENCY PRGM				874		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,246	1,246	276		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	92		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	184		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	486	486	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	10	10	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32	32	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16	16	0		59.00
60.00	06000	LABORATORY	0	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	92		69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03330	ENDOSCOPY	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	48	48	230		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,838	1,838	874		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07951	NONREIMBURSABLE	0	0	0	0		194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0		194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0		194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0		194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			INTERNS & RESIDENTS					
			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PHARMACY RESIDENCY PRGM (ASSIGNED TIME)		
			19.00	21.00	22.00	23.00		
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,988,049	184,018	745,607		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1,081.637106	100.118607	853.097254		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	23,125	32,751	20,731		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	12.581610	17.818825	23.719680		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	88,534,650		88,534,650	55,934	88,590,584	30.00
31.00	03100	INTENSIVE CARE UNIT	19,244,973		19,244,973	0	19,244,973	31.00
40.00	04000	SUBPROVIDER - IPF	4,069,527		4,069,527	30,393	4,099,920	40.00
43.00	04300	NURSERY	3,973,631		3,973,631	0	3,973,631	43.00
44.00	04400	SKILLED NURSING FACILITY	5,009,830		5,009,830	0	5,009,830	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,983,115		27,983,115	17,224	28,000,339	50.00
51.00	05100	RECOVERY ROOM	1,994,956		1,994,956	0	1,994,956	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,775,641		6,775,641	0	6,775,641	52.00
52.01	05201	PERINATAL CLINIC	2,430,177		2,430,177	0	2,430,177	52.01
53.00	05300	ANESTHESIOLOGY	992,060		992,060	33,665	1,025,725	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,824,669		12,824,669	0	12,824,669	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,293,135		6,293,135	3,732	6,296,867	55.00
56.00	05600	RADIOISOTOPE	1,769,532		1,769,532	0	1,769,532	56.00
57.00	05700	CT SCAN	3,066,776		3,066,776	0	3,066,776	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	959,976		959,976	0	959,976	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,888,512		3,888,512	16,510	3,905,022	59.00
60.00	06000	LABORATORY	6,920,868		6,920,868	0	6,920,868	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,301,281		4,301,281	0	4,301,281	62.00
64.00	06400	INTRAVENOUS THERAPY	4,740,111		4,740,111	383	4,740,494	64.00
65.00	06500	RESPIRATORY THERAPY	6,519,128	0	6,519,128	6,281	6,525,409	65.00
66.00	06600	PHYSICAL THERAPY	3,549,257	0	3,549,257	0	3,549,257	66.00
66.01	06601	CLINICAL NUTRITION	1,252,223	0	1,252,223	0	1,252,223	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,583,383	0	1,583,383	0	1,583,383	67.00
68.00	06800	SPEECH PATHOLOGY	623,015	0	623,015	0	623,015	68.00
69.00	06900	ELECTROCARDIOLOGY	6,990,064		6,990,064	0	6,990,064	69.00
69.01	06901	CARDIAC REHABILITATION	1,235,444		1,235,444	5,007	1,240,451	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	653,860		653,860	58,685	712,545	70.00
70.01	07001	ELECTROSHOCK THERAPY	317,375		317,375	0	317,375	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,040,104		37,040,104	0	37,040,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,719,009		26,719,009	0	26,719,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,174,412		64,174,412	0	64,174,412	73.00
74.00	07400	RENAL DIALYSIS	2,445,799		2,445,799	0	2,445,799	74.00
76.00	03330	ENDOSCOPY	2,533,551		2,533,551	0	2,533,551	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,148,568		15,148,568	61	15,148,629	90.00
91.00	09100	EMERGENCY	20,892,046		20,892,046	0	20,892,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,474,499		14,474,499		14,474,499	92.00
200.00		Subtotal (see instructions)	411,925,157	0	411,925,157	227,875	412,153,032	200.00
201.00		Less Observation Beds	14,474,499		14,474,499		14,474,499	201.00
202.00		Total (see instructions)	397,450,658	0	397,450,658	227,875	397,678,533	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	154,574,501		154,574,501		30.00
31.00	03100	INTENSIVE CARE UNIT	45,824,243		45,824,243		31.00
40.00	04000	SUBPROVIDER - IPF	7,786,032		7,786,032		40.00
43.00	04300	NURSERY	2,677,149		2,677,149		43.00
44.00	04400	SKILLED NURSING FACILITY	3,585,910		3,585,910		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	68,729,486	70,355,152	139,084,638	0.201195	0.000000
51.00	05100	RECOVERY ROOM	7,798,251	4,765,501	12,563,752	0.158787	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,165,509	4,259,016	13,424,525	0.504721	0.000000
52.01	05201	PERINATAL CLINIC	127,168	6,258,045	6,385,213	0.380595	0.000000
53.00	05300	ANESTHESIOLOGY	16,690,596	20,132,789	36,823,385	0.026941	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,737,926	52,520,372	79,258,298	0.161809	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,146,654	45,463,956	46,610,610	0.135015	0.000000
56.00	05600	RADIOISOTOPE	3,875,699	4,983,654	8,859,353	0.199736	0.000000
57.00	05700	CT SCAN	28,742,204	47,104,341	75,846,545	0.040434	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,220,288	13,125,718	19,346,006	0.049621	0.000000
59.00	05900	CARDIAC CATHETERIZATION	30,139,460	20,577,185	50,716,645	0.076671	0.000000
60.00	06000	LABORATORY	57,691,888	34,568,175	92,260,063	0.075015	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,737,386	2,590,769	11,328,155	0.379698	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,156,447	17,251,518	18,407,965	0.257503	0.000000
65.00	06500	RESPIRATORY THERAPY	21,272,662	8,126,106	29,398,768	0.221748	0.000000
66.00	06600	PHYSICAL THERAPY	6,237,870	1,362,841	7,600,711	0.466964	0.000000
66.01	06601	CLINICAL NUTRITION	0	169,374	169,374	7.393242	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,171,855	759,354	3,931,209	0.402773	0.000000
68.00	06800	SPEECH PATHOLOGY	2,390,676	330,580	2,721,256	0.228944	0.000000
69.00	06900	ELECTROCARDIOLOGY	25,515,349	52,394,229	77,909,578	0.089720	0.000000
69.01	06901	CARDIAC REHABILITATION	66,410	849,390	915,800	1.349033	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	3,572,637	4,404,966	7,977,603	0.081962	0.000000
70.01	07001	ELECTROSHOCK THERAPY	221,595	726,563	948,158	0.334728	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,236,467	12,672,808	24,909,275	1.487000	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,495,384	11,826,580	40,321,964	0.662642	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	68,593,915	261,436,876	330,030,791	0.194450	0.000000
74.00	07400	RENAL DIALYSIS	5,626,662	691,153	6,317,815	0.387127	0.000000
76.00	03330	ENDOSCOPY	3,656,645	13,493,621	17,150,266	0.147727	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	92,406	26,583,527	26,675,933	0.567874	0.000000
91.00	09100	EMERGENCY	40,856,859	69,384,133	110,240,992	0.189513	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,917,387	30,995,938	36,913,325	0.392121	0.000000
200.00		Subtotal (see instructions)	709,331,576	840,164,230	1,549,495,806		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	709,331,576	840,164,230	1,549,495,806		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.201319		50.00
51.00	05100	RECOVERY ROOM	0.158787		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.504721		52.00
52.01	05201	PERINATAL CLINIC	0.380595		52.01
53.00	05300	ANESTHESIOLOGY	0.027855		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161809		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135095		55.00
56.00	05600	RADIOISOTOPE	0.199736		56.00
57.00	05700	CT SCAN	0.040434		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.049621		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076997		59.00
60.00	06000	LABORATORY	0.075015		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698		62.00
64.00	06400	INTRAVENOUS THERAPY	0.257524		64.00
65.00	06500	RESPIRATORY THERAPY	0.221962		65.00
66.00	06600	PHYSICAL THERAPY	0.466964		66.00
66.01	06601	CLINICAL NUTRITION	7.393242		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.402773		67.00
68.00	06800	SPEECH PATHOLOGY	0.228944		68.00
69.00	06900	ELECTROCARDIOLOGY	0.089720		69.00
69.01	06901	CARDIAC REHABILITATION	1.354500		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.089318		70.00
70.01	07001	ELECTROSHOCK THERAPY	0.334728		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.662642		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194450		73.00
74.00	07400	RENAL DIALYSIS	0.387127		74.00
76.00	03330	ENDOSCOPY	0.147727		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.567876		90.00
91.00	09100	EMERGENCY	0.189513		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.392121		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet C
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			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	88,534,650		88,534,650	55,934	88,590,584	30.00
31.00	03100	INTENSIVE CARE UNIT	19,244,973		19,244,973	0	19,244,973	31.00
40.00	04000	SUBPROVIDER - IPF	4,069,527		4,069,527	30,393	4,099,920	40.00
43.00	04300	NURSERY	3,973,631		3,973,631	0	3,973,631	43.00
44.00	04400	SKILLED NURSING FACILITY	5,009,830		5,009,830	0	5,009,830	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,983,115		27,983,115	17,224	28,000,339	50.00
51.00	05100	RECOVERY ROOM	1,994,956		1,994,956	0	1,994,956	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,775,641		6,775,641	0	6,775,641	52.00
52.01	05201	PERINATAL CLINIC	2,430,177		2,430,177	0	2,430,177	52.01
53.00	05300	ANESTHESIOLOGY	992,060		992,060	33,665	1,025,725	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,824,669		12,824,669	0	12,824,669	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,293,135		6,293,135	3,732	6,296,867	55.00
56.00	05600	RADIOISOTOPE	1,769,532		1,769,532	0	1,769,532	56.00
57.00	05700	CT SCAN	3,066,776		3,066,776	0	3,066,776	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	959,976		959,976	0	959,976	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,888,512		3,888,512	16,510	3,905,022	59.00
60.00	06000	LABORATORY	6,920,868		6,920,868	0	6,920,868	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,301,281		4,301,281	0	4,301,281	62.00
64.00	06400	INTRAVENOUS THERAPY	4,740,111		4,740,111	383	4,740,494	64.00
65.00	06500	RESPIRATORY THERAPY	6,519,128	0	6,519,128	6,281	6,525,409	65.00
66.00	06600	PHYSICAL THERAPY	3,549,257	0	3,549,257	0	3,549,257	66.00
66.01	06601	CLINICAL NUTRITION	1,252,223	0	1,252,223	0	1,252,223	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,583,383	0	1,583,383	0	1,583,383	67.00
68.00	06800	SPEECH PATHOLOGY	623,015	0	623,015	0	623,015	68.00
69.00	06900	ELECTROCARDIOLOGY	6,990,064		6,990,064	0	6,990,064	69.00
69.01	06901	CARDIAC REHABILITATION	1,235,444		1,235,444	5,007	1,240,451	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	653,860		653,860	58,685	712,545	70.00
70.01	07001	ELECTROSHOCK THERAPY	317,375		317,375	0	317,375	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,040,104		37,040,104	0	37,040,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,719,009		26,719,009	0	26,719,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,174,412		64,174,412	0	64,174,412	73.00
74.00	07400	RENAL DIALYSIS	2,445,799		2,445,799	0	2,445,799	74.00
76.00	03330	ENDOSCOPY	2,533,551		2,533,551	0	2,533,551	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,148,568		15,148,568	61	15,148,629	90.00
91.00	09100	EMERGENCY	20,892,046		20,892,046	0	20,892,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,474,499		14,474,499		14,474,499	92.00
200.00		Subtotal (see instructions)	411,925,157	0	411,925,157	227,875	412,153,032	200.00
201.00		Less Observation Beds	14,474,499		14,474,499		14,474,499	201.00
202.00		Total (see instructions)	397,450,658	0	397,450,658	227,875	397,678,533	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
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			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	154,574,501		154,574,501		30.00
31.00	03100	INTENSIVE CARE UNIT	45,824,243		45,824,243		31.00
40.00	04000	SUBPROVIDER - IPF	7,786,032		7,786,032		40.00
43.00	04300	NURSERY	2,677,149		2,677,149		43.00
44.00	04400	SKILLED NURSING FACILITY	3,585,910		3,585,910		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	68,729,486	70,355,152	139,084,638	0.201195	0.000000
51.00	05100	RECOVERY ROOM	7,798,251	4,765,501	12,563,752	0.158787	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,165,509	4,259,016	13,424,525	0.504721	0.000000
52.01	05201	PERINATAL CLINIC	127,168	6,258,045	6,385,213	0.380595	0.000000
53.00	05300	ANESTHESIOLOGY	16,690,596	20,132,789	36,823,385	0.026941	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,737,926	52,520,372	79,258,298	0.161809	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,146,654	45,463,956	46,610,610	0.135015	0.000000
56.00	05600	RADIOISOTOPE	3,875,699	4,983,654	8,859,353	0.199736	0.000000
57.00	05700	CT SCAN	28,742,204	47,104,341	75,846,545	0.040434	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,220,288	13,125,718	19,346,006	0.049621	0.000000
59.00	05900	CARDIAC CATHETERIZATION	30,139,460	20,577,185	50,716,645	0.076671	0.000000
60.00	06000	LABORATORY	57,691,888	34,568,175	92,260,063	0.075015	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,737,386	2,590,769	11,328,155	0.379698	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,156,447	17,251,518	18,407,965	0.257503	0.000000
65.00	06500	RESPIRATORY THERAPY	21,272,662	8,126,106	29,398,768	0.221748	0.000000
66.00	06600	PHYSICAL THERAPY	6,237,870	1,362,841	7,600,711	0.466964	0.000000
66.01	06601	CLINICAL NUTRITION	0	169,374	169,374	7.393242	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,171,855	759,354	3,931,209	0.402773	0.000000
68.00	06800	SPEECH PATHOLOGY	2,390,676	330,580	2,721,256	0.228944	0.000000
69.00	06900	ELECTROCARDIOLOGY	25,515,349	52,394,229	77,909,578	0.089720	0.000000
69.01	06901	CARDIAC REHABILITATION	66,410	849,390	915,800	1.349033	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	3,572,637	4,404,966	7,977,603	0.081962	0.000000
70.01	07001	ELECTROSHOCK THERAPY	221,595	726,563	948,158	0.334728	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,236,467	12,672,808	24,909,275	1.487000	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,495,384	11,826,580	40,321,964	0.662642	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	68,593,915	261,436,876	330,030,791	0.194450	0.000000
74.00	07400	RENAL DIALYSIS	5,626,662	691,153	6,317,815	0.387127	0.000000
76.00	03330	ENDOSCOPY	3,656,645	13,493,621	17,150,266	0.147727	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	92,406	26,583,527	26,675,933	0.567874	0.000000
91.00	09100	EMERGENCY	40,856,859	69,384,133	110,240,992	0.189513	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,917,387	30,995,938	36,913,325	0.392121	0.000000
200.00		Subtotal (see instructions)	709,331,576	840,164,230	1,549,495,806		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	709,331,576	840,164,230	1,549,495,806		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
52.01	05201 PERINATAL CLINIC	0.000000			52.01
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
66.01	06601 CLINICAL NUTRITION	0.000000			66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901 CARDIAC REHABILITATION	0.000000			69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
70.01	07001 ELECTROSHOCK THERAPY	0.000000			70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
76.00	03330 ENDOSCOPY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,172,888	0	5,172,888	72,289	71.56	30.00	
31.00	INTENSIVE CARE UNIT	830,364		830,364	15,447	53.76	31.00	
40.00	SUBPROVIDER - IPF	910,834	0	910,834	27,681	32.90	40.00	
43.00	NURSERY	222,585		222,585	2,227	99.95	43.00	
44.00	SKILLED NURSING FACILITY	44,505		44,505	16,961	2.62	44.00	
200.00	Total (lines 30 through 199)	7,181,176		7,181,176	134,605		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	24,986	1,787,998					30.00
31.00	INTENSIVE CARE UNIT	1,892	101,714					31.00
40.00	SUBPROVIDER - IPF	1,912	62,905					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	2,872	7,525					44.00
200.00	Total (lines 30 through 199)	31,662	1,960,142					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,380,901	139,084,638	0.024308	29,152,620	708,642	50.00
51.00	05100 RECOVERY ROOM	20,905	12,563,752	0.001664	2,491,603	4,146	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	941,306	13,424,525	0.070118	7,627	535	52.00
52.01	05201 PERINATAL CLINIC	536,854	6,385,213	0.084078	0	0	52.01
53.00	05300 ANESTHESIOLOGY	145,426	36,823,385	0.003949	4,217,153	16,654	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	683,217	79,258,298	0.008620	6,247,192	53,851	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,060,574	46,610,610	0.022754	435,668	9,913	55.00
56.00	05600 RADIOISOTOPE	55,874	8,859,353	0.006307	1,361,232	8,585	56.00
57.00	05700 CT SCAN	370,182	75,846,545	0.004881	10,056,666	49,087	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	82,141	19,346,006	0.004246	2,106,127	8,943	58.00
59.00	05900 CARDIAC CATHETERIZATION	242,011	50,716,645	0.004772	6,713,802	32,038	59.00
60.00	06000 LABORATORY	759,422	92,260,063	0.008231	19,167,781	157,770	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	76,172	11,328,155	0.006724	1,822,060	12,252	62.00
64.00	06400 INTRAVENOUS THERAPY	428,263	18,407,965	0.023265	119,306	2,776	64.00
65.00	06500 RESPIRATORY THERAPY	404,859	29,398,768	0.013771	6,164,287	84,888	65.00
66.00	06600 PHYSICAL THERAPY	238,545	7,600,711	0.031385	2,109,845	66,217	66.00
66.01	06601 CLINICAL NUTRITION	11,538	169,374	0.068121	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	124,585	3,931,209	0.031691	1,012,426	32,085	67.00
68.00	06800 SPEECH PATHOLOGY	8,294	2,721,256	0.003048	914,306	2,787	68.00
69.00	06900 ELECTROCARDIOLOGY	469,091	77,909,578	0.006021	8,720,459	52,506	69.00
69.01	06901 CARDIAC REHABILITATION	258,079	915,800	0.281807	11,939	3,364	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	24,475	7,977,603	0.003068	1,126,733	3,457	70.00
70.01	07001 ELECTROSHOCK THERAPY	43,249	948,158	0.045614	4,029	184	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	686,250	24,909,275	0.027550	3,993,587	110,023	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	479,077	40,321,964	0.011881	9,928,685	117,963	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,149,867	330,030,791	0.003484	20,206,686	70,400	73.00
74.00	07400 RENAL DIALYSIS	60,501	6,317,815	0.009576	3,357,124	32,148	74.00
76.00	03330 ENDOSCOPY	396,861	17,150,266	0.023140	978,764	22,649	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,988,396	26,675,933	0.074539	225	17	90.00
91.00	09100 EMERGENCY	1,076,247	110,240,992	0.009763	10,722,770	104,686	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	845,180	36,913,325	0.022896	3,797,897	86,957	92.00
200.00	Total (lines 50 through 199)	17,048,342	1,335,047,971		156,948,599	1,855,523	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-0104		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/27/2020 1:44 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	235,455	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	78,485	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	156,970	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
200.00	Total (lines 30 through 199)		0	0	0	470,910	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	235,455	72,289	3.26	24,986	30.00		
31.00	03100	INTENSIVE CARE UNIT		78,485	15,447	5.08	1,892	31.00		
40.00	04000	SUBPROVIDER - IPF	0	156,970	27,681	5.67	1,912	40.00		
43.00	04300	NURSERY		0	2,227	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY		0	16,961	0.00	2,872	44.00		
200.00	Total (lines 30 through 199)			470,910	134,605		31,662	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	81,454						30.00	
31.00	03100	INTENSIVE CARE UNIT	9,611						31.00	
40.00	04000	SUBPROVIDER - IPF	10,841						40.00	
43.00	04300	NURSERY	0						43.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
200.00	Total (lines 30 through 199)		101,906						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	78,485	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	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	196,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	38,473	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	313,170	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 26-0104		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	139,084,638	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,563,752	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,424,525	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	6,385,213	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	36,823,385	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,258,298	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	46,610,610	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,859,353	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	75,846,545	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,346,006	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	50,716,645	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	92,260,063	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	11,328,155	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	18,407,965	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,398,768	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,600,711	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	169,374	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,931,209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,721,256	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	78,485	78,485	77,909,578	0.001007	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	915,800	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,977,603	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	948,158	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	24,909,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,321,964	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	330,030,791	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,317,815	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	17,150,266	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	26,675,933	0.000000	90.00
91.00	09100	EMERGENCY	0	196,212	196,212	110,240,992	0.001780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	38,473	38,473	36,913,325	0.001042	92.00
200.00		Total (lines 50 through 199)	0	313,170	313,170	1,335,047,971		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 1:44 pm

				Title XVIII		Hospital	PPS	
	Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	29,152,620	0	37,857,521	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,491,603	0	2,995,787	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	7,627	0	14,450	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	4,217,153	0	3,008,747	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,247,192	0	8,369,908	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	435,668	0	15,877,436	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	1,361,232	0	1,919,658	0	56.00
57.00	05700	CT SCAN	0.000000	10,056,666	0	8,851,851	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,106,127	0	3,826,790	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	6,713,802	0	3,695,341	0	59.00
60.00	06000	LABORATORY	0.000000	19,167,781	0	6,715,528	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,822,060	0	174,422	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	119,306	0	2,172,733	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,164,287	0	1,255,218	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,109,845	0	50,023	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,012,426	0	21,030	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	914,306	0	39,572	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001007	8,720,459	8,782	5,567,841	5,607	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	11,939	0	306,145	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,126,733	0	1,098,977	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	4,029	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,993,587	0	4,566,303	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,928,685	0	2,564,813	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	20,206,686	0	82,395,079	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	3,357,124	0	353,707	0	74.00
76.00	03330	ENDOSCOPY	0.000000	978,764	0	1,844,669	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	225	0	6,777,774	0	90.00
91.00	09100	EMERGENCY	0.001780	10,722,770	19,087	7,601,136	13,530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.001042	3,797,897	3,957	7,102,865	7,401	92.00
200.00	Total (lines 50 through 199)			156,948,599	31,826	217,025,324	26,538	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 1:44 pm

			Title XVIII		Hospital		PPS	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.201195	37,857,521	0	0	7,616,744	50.00
51.00	05100	RECOVERY ROOM	0.158787	2,995,787	0	0	475,692	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.504721	14,450	0	0	7,293	52.00
52.01	05201	PERINATAL CLINIC	0.380595	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.026941	3,008,747	0	0	81,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161809	8,369,908	0	0	1,354,326	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135015	15,877,436	0	0	2,143,692	55.00
56.00	05600	RADIOISOTOPE	0.199736	1,919,658	0	0	383,425	56.00
57.00	05700	CT SCAN	0.040434	8,851,851	0	0	357,916	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.049621	3,826,790	0	0	189,889	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076671	3,695,341	0	0	283,325	59.00
60.00	06000	LABORATORY	0.075015	6,715,528	0	0	503,765	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698	174,422	0	0	66,228	62.00
64.00	06400	INTRAVENOUS THERAPY	0.257503	2,172,733	0	0	559,485	64.00
65.00	06500	RESPIRATORY THERAPY	0.221748	1,255,218	0	0	278,342	65.00
66.00	06600	PHYSICAL THERAPY	0.466964	50,023	0	0	23,359	66.00
66.01	06601	CLINICAL NUTRITION	7.393242	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.402773	21,030	0	0	8,470	67.00
68.00	06800	SPEECH PATHOLOGY	0.228944	39,572	0	0	9,060	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089720	5,567,841	0	0	499,547	69.00
69.01	06901	CARDIAC REHABILITATION	1.349033	306,145	0	0	413,000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081962	1,098,977	0	0	90,074	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.334728	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000	4,566,303	0	0	6,790,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.662642	2,564,813	0	0	1,699,553	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194450	82,395,079	657	374,994	16,021,723	73.00
74.00	07400	RENAL DIALYSIS	0.387127	353,707	0	0	136,930	74.00
76.00	03330	ENDOSCOPY	0.147727	1,844,669	0	0	272,507	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.567874	6,777,774	0	648	3,848,922	90.00
91.00	09100	EMERGENCY	0.189513	7,601,136	0	0	1,440,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.392121	7,102,865	0	0	2,785,183	92.00
200.00		Subtotal (see instructions)		217,025,324	657	375,642	48,340,116	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		217,025,324	657	375,642	48,340,116	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 26-0104		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/27/2020 1:44 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128	72,918		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03330	ENDOSCOPY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	368		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	128	73,286		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	128	73,286		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/27/2020 1:44 pm		
				Component CCN: 26-S104				
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,380,901	139,084,638	0.024308	5,402	131	50.00
51.00	05100	RECOVERY ROOM	20,905	12,563,752	0.001664	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	941,306	13,424,525	0.070118	0	0	52.00
52.01	05201	PERINATAL CLINIC	536,854	6,385,213	0.084078	0	0	52.01
53.00	05300	ANESTHESIOLOGY	145,426	36,823,385	0.003949	9,462	37	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	683,217	79,258,298	0.008620	13,977	120	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,060,574	46,610,610	0.022754	288	7	55.00
56.00	05600	RADIOISOTOPE	55,874	8,859,353	0.006307	3,784	24	56.00
57.00	05700	CT SCAN	370,182	75,846,545	0.004881	24,000	117	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	82,141	19,346,006	0.004246	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	242,011	50,716,645	0.004772	0	0	59.00
60.00	06000	LABORATORY	759,422	92,260,063	0.008231	438,360	3,608	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	76,172	11,328,155	0.006724	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	428,263	18,407,965	0.023265	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	404,859	29,398,768	0.013771	9,970	137	65.00
66.00	06600	PHYSICAL THERAPY	238,545	7,600,711	0.031385	0	0	66.00
66.01	06601	CLINICAL NUTRITION	11,538	169,374	0.068121	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	124,585	3,931,209	0.031691	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,294	2,721,256	0.003048	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	469,091	77,909,578	0.006021	17,587	106	69.00
69.01	06901	CARDIAC REHABILITATION	258,079	915,800	0.281807	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	24,475	7,977,603	0.003068	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	43,249	948,158	0.045614	38,947	1,777	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	686,250	24,909,275	0.027550	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	479,077	40,321,964	0.011881	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,149,867	330,030,791	0.003484	431,211	1,502	73.00
74.00	07400	RENAL DIALYSIS	60,501	6,317,815	0.009576	7,800	75	74.00
76.00	03330	ENDOSCOPY	396,861	17,150,266	0.023140	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,988,396	26,675,933	0.074539	0	0	90.00
91.00	09100	EMERGENCY	1,076,247	110,240,992	0.009763	285,630	2,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	36,913,325	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	16,203,162	1,335,047,971		1,286,418	10,430	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	78,485	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		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	196,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	274,697	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	139,084,638	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	12,563,752	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	13,424,525	0.000000	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	6,385,213	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	36,823,385	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	79,258,298	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	46,610,610	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	8,859,353	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	75,846,545	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	19,346,006	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	50,716,645	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	92,260,063	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	11,328,155	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	18,407,965	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	29,398,768	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,600,711	0.000000	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	169,374	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,931,209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	2,721,256	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	78,485	78,485	77,909,578	0.001007	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	915,800	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	7,977,603	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	948,158	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	24,909,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	40,321,964	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	330,030,791	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	6,317,815	0.000000	74.00
76.00	03330	ENDOSCOPY		0	0	0	17,150,266	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	26,675,933	0.000000	90.00
91.00	09100	EMERGENCY		0	196,212	196,212	110,240,992	0.001780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	36,913,325	0.000000	92.00
200.00		Total (lines 50 through 199)		0	274,697	274,697	1,335,047,971		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		5,402	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000		0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000		9,462	0	19,250	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		13,977	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		288	0	720	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		3,784	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		24,000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		438,360	0	228	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		9,970	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000		0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001007		17,587	18	591	1	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000		38,947	0	76,551	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		431,211	0	72,164	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		7,800	0	0	0	74.00
76.00	03330	ENDOSCOPY	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	0.001780		285,630	508	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,286,418	526	169,504	1	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/27/2020 1:44 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.201195	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.158787	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.504721	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.380595	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.026941	19,250	0	0	519	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161809	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135015	720	0	0	97	55.00
56.00	05600	RADIOISOTOPE	0.199736	0	0	0	0	56.00
57.00	05700	CT SCAN	0.040434	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.049621	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076671	0	0	0	0	59.00
60.00	06000	LABORATORY	0.075015	228	0	0	17	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.257503	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.221748	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.466964	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	7.393242	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.402773	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.228944	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089720	591	0	0	53	69.00
69.01	06901	CARDIAC REHABILITATION	1.349033	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081962	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.334728	76,551	0	0	25,624	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.662642	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194450	72,164	0	0	14,032	73.00
74.00	07400	RENAL DIALYSIS	0.387127	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.147727	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.567874	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.189513	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.392121	0	0	0	0	92.00
200.00		Subtotal (see instructions)		169,504	0	0	40,342	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		169,504	0	0	40,342	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:

Worksheet D

Component CCN: 26-S104

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/27/2020 1:44 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	78,485	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		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	196,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	274,697	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	139,084,638	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	12,563,752	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	13,424,525	0.000000	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	6,385,213	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	36,823,385	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	79,258,298	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	46,610,610	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	8,859,353	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	75,846,545	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	19,346,006	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	50,716,645	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	92,260,063	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	11,328,155	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	18,407,965	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	29,398,768	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,600,711	0.000000	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	169,374	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,931,209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	2,721,256	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	78,485	78,485	77,909,578	0.001007	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	915,800	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	7,977,603	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	948,158	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	24,909,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	40,321,964	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	330,030,791	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	6,317,815	0.000000	74.00
76.00	03330	ENDOSCOPY		0	0	0	17,150,266	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	26,675,933	0.000000	90.00
91.00	09100	EMERGENCY		0	196,212	196,212	110,240,992	0.001780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	36,913,325	0.000000	92.00
200.00		Total (lines 50 through 199)		0	274,697	274,697	1,335,047,971		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,422	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	6,454	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	324,553	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	322,280	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	165,577	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001007	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,192	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	84,493	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.001780	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			909,971	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 1:44 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.201195	0	3,393,498	0	0	50.00
51.00	05100	RECOVERY ROOM	0.158787	0	390,876	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.504721	0	418,860	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.380595	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.026941	0	449,503	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161809	0	2,619,449	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135015	0	2,338,138	0	0	55.00
56.00	05600	RADIOISOTOPE	0.199736	0	374,567	0	0	56.00
57.00	05700	CT SCAN	0.040434	0	3,469,521	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.049621	0	639,000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076671	0	612,120	0	0	59.00
60.00	06000	LABORATORY	0.075015	0	3,672,218	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698	0	44,671	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.257503	0	9,902	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.221748	0	215,034	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.466964	0	23,540	0	0	66.00
66.01	06601	CLINICAL NUTRITION	7.393242	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.402773	0	15,532	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.228944	0	7,508	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089720	0	1,264,428	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1.349033	0	36,510	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081962	0	377,262	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.334728	0	212,194	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000	0	374,295	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.662642	0	346,013	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194450	0	12,967,211	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.387127	0	74,290	0	0	74.00
76.00	03330	ENDOSCOPY	0.147727	0	205,578	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.567874	0	2,025,187	0	0	90.00
91.00	09100	EMERGENCY	0.189513	0	6,520,506	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.392121	0	2,133,654	0	0	92.00
200.00		Subtotal (see instructions)		0	45,231,065	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	45,231,065	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 1:44 pm

			Title XIX		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	682,755	0		50.00
51.00	05100	RECOVERY ROOM	62,066	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	211,407	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
53.00	05300	ANESTHESIOLOGY	12,110	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,850	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	315,684	0		55.00
56.00	05600	RADIOISOTOPE	74,815	0		56.00
57.00	05700	CT SCAN	140,287	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	31,708	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	46,932	0		59.00
60.00	06000	LABORATORY	275,471	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	16,961	0		62.00
64.00	06400	INTRAVENOUS THERAPY	2,550	0		64.00
65.00	06500	RESPIRATORY THERAPY	47,683	0		65.00
66.00	06600	PHYSICAL THERAPY	10,992	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	6,256	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,719	0		68.00
69.00	06900	ELECTROCARDIOLOGY	113,444	0		69.00
69.01	06901	CARDIAC REHABILITATION	49,253	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	30,921	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	71,027	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	556,577	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	229,283	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,521,474	0		73.00
74.00	07400	RENAL DIALYSIS	28,760	0		74.00
76.00	03330	ENDOSCOPY	30,369	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,150,051	0		90.00
91.00	09100	EMERGENCY	1,235,721	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	836,651	0		92.00
200.00		Subtotal (see instructions)	9,216,777	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,216,777	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	78,485	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		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	196,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	274,697	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	139,084,638	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	12,563,752	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	13,424,525	0.000000	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	6,385,213	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	36,823,385	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	79,258,298	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	46,610,610	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	8,859,353	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	75,846,545	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	19,346,006	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	50,716,645	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	92,260,063	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	11,328,155	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	18,407,965	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	29,398,768	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,600,711	0.000000	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	169,374	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,931,209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	2,721,256	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	78,485	78,485	77,909,578	0.001007	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	915,800	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	7,977,603	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	948,158	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	24,909,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	40,321,964	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	330,030,791	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	6,317,815	0.000000	74.00
76.00	03330	ENDOSCOPY		0	0	0	17,150,266	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	26,675,933	0.000000	90.00
91.00	09100	EMERGENCY		0	196,212	196,212	110,240,992	0.001780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	36,913,325	0.000000	92.00
200.00		Total (lines 50 through 199)		0	274,697	274,697	1,335,047,971		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001007	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.001780	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		72,289	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		72,289	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)		60,478	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		24,986	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)		88,590,584	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)		88,590,584	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)		88,590,584	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,225.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		30,620,593	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)		30,620,593	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm	
				Title XVIII		Hospital	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	19,244,973	15,447	1,245.87	1,892	2,357,186	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)					36,199,663	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					69,177,442	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)					1,980,777	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,887,349	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,868,126	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					65,309,316	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)					11,811	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,225.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					14,474,499	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,172,888	88,590,584	0.058391	14,474,499	845,180
91.00	Nursing School cost	0	88,590,584	0.000000	14,474,499	0
92.00	Allied health cost	235,455	88,590,584	0.002658	14,474,499	38,473
93.00	All other Medical Education	0	88,590,584	0.000000	14,474,499	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		27,681	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		27,681	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)		27,681	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,912	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)		4,099,920	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)		4,099,920	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)		4,099,920	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)		148.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		283,186	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)		283,186	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					196,091	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					479,277	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)					73,746	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,956	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					84,702	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					394,575	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: 26-0104

Period:

Worksheet D-1

Component CCN: 26-S104

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

8/27/2020 1:44 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	910,834	4,099,920	0.222159	0	0	90.00
91.00	Nursing School cost	0	4,099,920	0.000000	0	0	91.00
92.00	Allied health cost	156,970	4,099,920	0.038286	0	0	92.00
93.00	All other Medical Education	0	4,099,920	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,961	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,961	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)		16,961	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,872	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)		5,009,830	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)		5,009,830	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)		5,009,830	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XVIII		Skilled Nursing Facility	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)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					5,009,830	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					295.37	71.00
72.00 Program routine service cost (line 9 x line 71)					848,303	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					848,303	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					848,303	83.00
84.00 Program inpatient ancillary services (see instructions)					340,159	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					1,188,462	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: 26-0104

Period:

Worksheet D-1

Component CCN: 26-5842

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/27/2020 1:44 pm

Title XVIII

Skilled Nursing
Facility

PPS

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		72,289	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		72,289	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)		60,478	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		12,613	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)		2,227	15.00	
16.00	Nursery days (title V or XIX only)		228	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)		88,534,650	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)		88,534,650	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)		88,534,650	37.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,224.73	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,447,519	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)		15,447,519	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 1:44 pm

		Title XIX		Hospital		Cost	
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)	3,973,631	2,227	1,784.30	228	406,820	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	19,244,973	15,447	1,245.87	1,532	1,908,673	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)					8,184,116	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,947,128	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)					11,811	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,224.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					14,465,286	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 1:44 pm

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	5,172,888	88,534,650	0.058428	14,465,286	845,178	90.00
91.00	Nursing School cost	0	88,534,650	0.000000	14,465,286	0	91.00
92.00	Allied health cost	0	88,534,650	0.000000	14,465,286	0	92.00
93.00	All other Medical Education	0	88,534,650	0.000000	14,465,286	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			27,681 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			27,681 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)			27,681 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			9,873 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)			2,227 15.00
16.00	Nursery days (title V or XIX only)			228 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)			4,069,527 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)			4,069,527 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)			4,069,527 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)			147.02 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,451,528 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,451,528 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XIX		Subprovider - IPF	Cost	
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)	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					143,115	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,594,643	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: 26-0104 Component CCN: 26-S104		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	910,834	4,069,527	0.223818	0	0	90.00
91.00	Nursing School cost	0	4,069,527	0.000000	0	0	91.00
92.00	Allied health cost	0	4,069,527	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,069,527	0.000000	0	0	93.00

Health Financial Systems		SSM HEALTH DEPAUL HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1	
		Component CCN: 26-5842		Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XIX	Skilled Nursing Facility	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			16,961	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			16,961	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)			16,961	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			12,383	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)			2,227	15.00
16.00	Nursery days (title V or XIX only)			228	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)			5,009,830	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)			5,009,830	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)			5,009,830	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)				38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)				39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)				40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)				41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XIX		Skilled Nursing Facility	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)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					5,009,830	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					295.37	71.00
72.00 Program routine service cost (line 9 x line 71)					3,657,567	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					3,657,567	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					44,505	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					2.62	76.00
77.00 Program capital-related costs (line 9 x line 76)					32,443	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					3,625,124	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					3,625,124	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					32,443	83.00
84.00 Program inpatient ancillary services (see instructions)					0	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					32,443	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: 26-0104

Period:

Worksheet D-1

Component CCN: 26-5842

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/27/2020 1:44 pm

Title XIX

Skilled Nursing
Facility

PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 1:44 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		42,101,031	30.00
31.00	03100	INTENSIVE CARE UNIT		15,192,987	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.201319	29,152,620	50.00
51.00	05100	RECOVERY ROOM	0.158787	2,491,603	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.504721	7,627	52.00
52.01	05201	PERINATAL CLINIC	0.380595	0	52.01
53.00	05300	ANESTHESIOLOGY	0.027855	4,217,153	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161809	6,247,192	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135095	435,668	55.00
56.00	05600	RADIOISOTOPE	0.199736	1,361,232	56.00
57.00	05700	CT SCAN	0.040434	10,056,666	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.049621	2,106,127	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076997	6,713,802	59.00
60.00	06000	LABORATORY	0.075015	19,167,781	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698	1,822,060	62.00
64.00	06400	INTRAVENOUS THERAPY	0.257524	119,306	64.00
65.00	06500	RESPIRATORY THERAPY	0.221962	6,164,287	65.00
66.00	06600	PHYSICAL THERAPY	0.466964	2,109,845	66.00
66.01	06601	CLINICAL NUTRITION	7.393242	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.402773	1,012,426	67.00
68.00	06800	SPEECH PATHOLOGY	0.228944	914,306	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089720	8,720,459	69.00
69.01	06901	CARDIAC REHABILITATION	1.354500	11,939	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.089318	1,126,733	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.334728	4,029	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000	3,993,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.662642	9,928,685	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194450	20,206,686	73.00
74.00	07400	RENAL DIALYSIS	0.387127	3,357,124	74.00
76.00	03330	ENDOSCOPY	0.147727	978,764	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.567876	225	90.00
91.00	09100	EMERGENCY	0.189513	10,722,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.392121	3,797,897	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		156,948,599	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		156,948,599	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		2,875,290		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.201319	5,402	1,088	50.00
51.00	05100 RECOVERY ROOM	0.158787	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.504721	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.380595	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.027855	9,462	264	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.161809	13,977	2,262	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.135095	288	39	55.00
56.00	05600 RADIOISOTOPE	0.199736	3,784	756	56.00
57.00	05700 CT SCAN	0.040434	24,000	970	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.049621	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.076997	0	0	59.00
60.00	06000 LABORATORY	0.075015	438,360	32,884	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.257524	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.221962	9,970	2,213	65.00
66.00	06600 PHYSICAL THERAPY	0.466964	0	0	66.00
66.01	06601 CLINICAL NUTRITION	7.393242	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.402773	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.228944	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.089720	17,587	1,578	69.00
69.01	06901 CARDIAC REHABILITATION	1.354500	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.089318	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.334728	38,947	13,037	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.662642	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.194450	431,211	83,849	73.00
74.00	07400 RENAL DIALYSIS	0.387127	7,800	3,020	74.00
76.00	03330 ENDOSCOPY	0.147727	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.567876	0	0	90.00
91.00	09100 EMERGENCY	0.189513	285,630	54,131	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.392121	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,286,418	196,091	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)		1,286,418		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.201319	0	0	50.00
51.00	05100 RECOVERY ROOM	0.158787	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.504721	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.380595	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.027855	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.161809	4,422	716	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.135095	0	0	55.00
56.00	05600 RADIOISOTOPE	0.199736	0	0	56.00
57.00	05700 CT SCAN	0.040434	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.049621	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.076997	0	0	59.00
60.00	06000 LABORATORY	0.075015	6,454	484	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.257524	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.221962	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.466964	324,553	151,555	66.00
66.01	06601 CLINICAL NUTRITION	7.393242	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.402773	322,280	129,806	67.00
68.00	06800 SPEECH PATHOLOGY	0.228944	165,577	37,908	68.00
69.00	06900 ELECTROCARDIOLOGY	0.089720	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	1.354500	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.089318	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.334728	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000	2,192	3,260	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.662642	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.194450	84,493	16,430	73.00
74.00	07400 RENAL DIALYSIS	0.387127	0	0	74.00
76.00	03330 ENDOSCOPY	0.147727	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.567876	0	0	90.00
91.00	09100 EMERGENCY	0.189513	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.392121	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		909,971	340,159	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)		909,971		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 1:44 pm	
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		24,124,507		30.00
31.00	03100	INTENSIVE CARE UNIT		4,398,016		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		257,854		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.201195	4,898,127	985,479	50.00
51.00	05100	RECOVERY ROOM	0.158787	313,964	49,853	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.504721	433,448	218,770	52.00
52.01	05201	PERINATAL CLINIC	0.380595	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.026941	838,588	22,592	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161809	1,445,638	233,917	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135015	232,540	31,396	55.00
56.00	05600	RADIOISOTOPE	0.199736	376,745	75,250	56.00
57.00	05700	CT SCAN	0.040434	2,673,723	108,109	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.049621	628,240	31,174	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076671	1,147,393	87,972	59.00
60.00	06000	LABORATORY	0.075015	7,990,888	599,436	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698	476,709	181,005	62.00
64.00	06400	INTRAVENOUS THERAPY	0.257503	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.221748	1,885,396	418,083	65.00
66.00	06600	PHYSICAL THERAPY	0.466964	339,615	158,588	66.00
66.01	06601	CLINICAL NUTRITION	7.393242	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.402773	201,533	81,172	67.00
68.00	06800	SPEECH PATHOLOGY	0.228944	164,014	37,550	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089720	1,825,164	163,754	69.00
69.01	06901	CARDIAC REHABILITATION	1.349033	2,080	2,806	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081962	392,021	32,131	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.334728	72,522	24,275	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000	762,426	1,133,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.662642	706,231	467,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194450	7,685,781	1,494,500	73.00
74.00	07400	RENAL DIALYSIS	0.387127	422,934	163,729	74.00
76.00	03330	ENDOSCOPY	0.147727	233,936	34,559	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.567874	26,014	14,773	90.00
91.00	09100	EMERGENCY	0.189513	5,135,420	973,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.392121	913,772	358,309	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		42,224,862	8,184,116	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		42,224,862		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		2,305,106		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.201195	0	0	50.00
51.00	05100 RECOVERY ROOM	0.158787	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.504721	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.380595	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.026941	1,500	40	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.161809	7,918	1,281	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.135015	0	0	55.00
56.00	05600 RADIOISOTOPE	0.199736	0	0	56.00
57.00	05700 CT SCAN	0.040434	31,900	1,290	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.049621	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.076671	0	0	59.00
60.00	06000 LABORATORY	0.075015	394,432	29,588	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.379698	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.257503	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.221748	2,110	468	65.00
66.00	06600 PHYSICAL THERAPY	0.466964	0	0	66.00
66.01	06601 CLINICAL NUTRITION	7.393242	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.402773	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.228944	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.089720	7,931	712	69.00
69.01	06901 CARDIAC REHABILITATION	1.349033	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.081962	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.334728	6,715	2,248	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.487000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.662642	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.194450	302,538	58,829	73.00
74.00	07400 RENAL DIALYSIS	0.387127	0	0	74.00
76.00	03330 ENDOSCOPY	0.147727	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.567874	1,236	702	90.00
91.00	09100 EMERGENCY	0.189513	253,055	47,957	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.392121	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,009,335	143,115	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)		1,009,335		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		38,366,355	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		13,101,330	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		476,724	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		384,884	2.04
3.00	Managed Care Simulated Payments		40,873,870	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		376.64	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		14.01	11.00
12.00	Current year allowable FTE (see instructions)		14.01	12.00
13.00	Total allowable FTE count for the prior year.		13.17	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		14.22	14.00
15.00	Sum of lines 12 through 14 divided by 3.		13.80	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		13.80	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.036640	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.033155	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.033155	21.00
22.00	IME payment adjustment (see instructions)		923,948	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		733,768	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		923,948	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		733,768	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.72	30.00
31.00	Percentage of Medicaid patient days (see instructions)		34.93	31.00
32.00	Sum of lines 30 and 31		40.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)		16.61	33.00
34.00	Disproportionate share adjustment (see instructions)		2,137,196	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000781362	0.000773848	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	6,464,106	6,462,091	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,834,796	1,624,350	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	6,459,146		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	61,849,583		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		62,583,351	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,608,637	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		468,942	52.00
53.00	Nursing and Allied Health Managed Care payment		80,432	53.00
54.00	Special add-on payments for new technologies		1,400	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		91,065	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		31,826	58.00
59.00	Total (sum of amounts on lines 49 through 58)		67,865,653	59.00
60.00	Primary payer payments		96,547	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		67,769,106	61.00
62.00	Deductibles billed to program beneficiaries		4,742,768	62.00
63.00	Coinurance billed to program beneficiaries		381,166	63.00
64.00	Allowable bad debts (see instructions)		1,804,456	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		1,172,896	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,333,587	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		63,818,068	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-146,357	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		63,671,711	71.00
71.01	Sequestration adjustment (see instructions)		1,273,434	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		61,170,987	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,227,290	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,080,297	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/27/2020 1:44 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	38,366,355	0	38,366,355		38,366,355
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,101,330	0		13,101,330	13,101,330
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	476,724	0	476,724		476,724
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	384,884	0		384,884	384,884
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	40,873,870	0	30,460,703	10,413,166	40,873,869
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.033155	0.033155	0.033155	0.033155	
6.00	IME payment adjustment (see instructions)	22.00	923,948	0	688,753	235,195	923,948
6.01	IME payment adjustment for managed care (see instructions)	22.01	733,768	0	546,831	186,937	733,768
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	923,948	0	688,753	235,195	923,948
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	733,768	0	546,831	186,937	733,768
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1661	0.1661	0.1661	0.1661	
11.00	Disproportionate share adjustment (see instructions)	34.00	2,137,196	0	1,593,163	544,033	2,137,196
11.01	Uncompensated care payments	36.00	6,459,146	0	4,834,796	1,624,350	6,459,146
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	61,849,583	0	45,959,791	15,889,792	61,849,583
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	62,583,351	0	46,506,622	16,076,729	62,583,351
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	4,608,637	0	3,443,013	1,165,624	4,608,637

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/27/2020 1:44 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	1,400	0	1,400	0	1,400	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	49,951,035	17,242,353	67,193,388	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	4,138,892	0	3,099,892	1,039,000	4,138,892	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	38,058	0	19,802	18,256	38,058	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0185	0.0185	0.0185	0.0185		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	76,570	0	57,348	19,222	76,570	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0858	0.0858	0.0858	0.0858		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	355,117	0	265,971	89,146	355,117	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,608,637	0	3,443,013	1,165,624	4,608,637	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/27/2020 1:44 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	38,366,355	38,366,355		38,366,355	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,101,330		13,101,330	13,101,330	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	476,724	476,724		476,724	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	384,884		384,884	384,884	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	40,873,870	30,460,703	10,413,166	40,873,869	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.033155	0.033155	0.033155		5.00
6.00	IME payment adjustment (see instructions)	22.00	923,948	688,753	235,195	923,948	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	733,768	546,831	186,937	733,768	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	923,948	688,753	235,195	923,948	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	733,768	546,831	186,937	733,768	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1661	0.1661	0.1661		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,137,196	1,593,163	544,033	2,137,196	11.00
11.01	Uncompensated care payments	36.00	6,459,146	4,834,796	1,624,350	6,459,146	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	61,849,583	45,959,791	15,889,792	61,849,583	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	62,583,351	46,506,622	16,076,729	62,583,351	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	4,608,637	3,443,013	1,165,624	4,608,637	16.00
17.00	Special add-on payments for new technologies	54.00	1,400	1,400	0	1,400	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			49,951,035	17,242,353	67,193,388	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/27/2020 1:44 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	4,138,892	3,099,892	1,039,000	4,138,892	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	38,058	19,802	18,256	38,058	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0185	0.0185	0.0185		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	76,570	57,348	19,222	76,570	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0858	0.0858	0.0858		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	355,117	265,971	89,146	355,117	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,608,637	3,443,013	1,165,624	4,608,637	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-146,357	-122,774	-23,583	-146,357	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

Health Financial Systems		SSM HEALTH DEPAUL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		73,414	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		48,313,578	2.00	
3.00	OPPS payments		40,767,824	3.00	
4.00	Outlier payment (see instructions)		80,377	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		26,538	9.00	
10.00	Organ acquisitions		0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)		73,414	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		376,299	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)		376,299	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)		376,299	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		302,885	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)		73,414	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)		40,874,739	24.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		7,822,598	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)		33,125,555	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		315,789	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)		33,441,344	30.00	
31.00	Primary payer payments		21,606	31.00	
32.00	Subtotal (line 30 minus line 31)		33,419,738	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)		765,202	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		497,381	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		371,329	36.00	
37.00	Subtotal (see instructions)		33,917,119	37.00	
38.00	MSP-LCC reconciliation amount from PS&R		2,685	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)		33,914,434	40.00	
40.01	Sequestration adjustment (see instructions)		678,289	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
40.03	Sequestration adjustment-PARHM pass-throughs			40.03	
41.00	Interim payments		33,254,628	41.00	
41.01	Interim payments-PARHM			41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01	
43.00	Balance due provider/program (see instructions)		-18,483	43.00	
43.01	Balance due provider/program-PARHM (see instructions)			43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00	
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)		0	90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00	
92.00	The rate used to calculate the Time Value of Money		0.00	92.00	
93.00	Time Value of Money (see instructions)			93.00	
94.00	Total (sum of lines 91 and 93)		0	94.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Subprovider - IPF	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 OPPI (see instructions)		40,341	2.00
3.00	OPPI payments		37,877	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		1	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)		37,878	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		7,617	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)		30,261	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)		30,261	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		30,261	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)		30,261	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)		30,261	40.00
40.01	Sequestration adjustment (see instructions)		605	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		29,655	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		1	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/27/2020 1:44 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		59,119,069		32,408,370	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,936,518		788,358	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	08/13/2019	26,100	08/13/2019	57,900	3.01
3.02		11/26/2019	89,300		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		115,400		57,900	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)		61,170,987		33,254,628	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		1,227,290		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		18,483	6.02
7.00	Total Medicare program liability (see instructions)		62,398,277		33,236,145	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104

Period:

Worksheet E-1

Component CCN: 26-S104

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,276,011		29,655	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)		82,544		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,358,555		29,655	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		30,349		0	6.02
7.00	Total Medicare program liability (see instructions)		1,328,206		29,656	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104

Period:

Worksheet E-1

Component CCN: 26-5842

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/27/2020 1:44 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,363,733		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,363,733		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		3,602		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,367,335		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/27/2020 1:44 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	8.00
9.00	Sequestration adjustment amount (see instructions)	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	30.00
31.00	Other Adjustment (specify)	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,586,531	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		9,269	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		75.838356	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,595,800	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,595,800	16.00
17.00	Primary payer payments		2,890	17.00
18.00	Subtotal (line 16 less line 17).		1,592,910	18.00
19.00	Deductibles		263,180	19.00
20.00	Subtotal (line 18 minus line 19)		1,329,730	20.00
21.00	Coinsurance		27,609	21.00
22.00	Subtotal (line 20 minus line 21)		1,302,121	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		64,345	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		41,824	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		17,673	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,343,945	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		11,367	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,355,312	31.00
31.01	Sequestration adjustment (see instructions)		27,106	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		1,358,555	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)		-30,349	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: 26-0104 Component CCN: 26-5842	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,515,688	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,515,688	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		124,124	7.00
8.00	Allowable bad debts (see instructions)		5,656	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		5,656	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		3,676	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,395,240	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,395,240	15.00
15.01	Sequestration adjustment (see instructions)		27,905	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		1,363,733	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		3,602	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		14.01		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		14.01		10.01
11.00	Total weighted FTE count	0.00	14.01		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	13.17		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	14.22		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	13.80		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	13.80		17.00
18.00	Per resident amount	121,883.14	121,883.14		18.00
19.00	Approved amount for resident costs	0	1,681,987	1,681,987	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,681,987	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	28,790	21,250		26.00
27.00	Total Inpatient Days (see instructions)	104,067	104,067		27.00
28.00	Ratio of inpatient days to total inpatient days	0.276649	0.204195		28.00
29.00	Program direct GME amount	465,320	343,453	808,773	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		24,042	24,042	30.00
31.00	Net Program direct GME amount			784,731	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 8/27/2020 1:44 pm	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		6,317,815		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		72,020,710		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		99,437		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		71,921,273		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		48,453,872		42.00
43.00	Primary payer payments (see instructions)		21,606		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		48,432,266		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		120,353,539		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.597583		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.402417		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		784,731		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		468,942		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		315,789		50.00

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

Provider CCN: 26-0104

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

Worksheet G

Date/Time Prepared:
8/27/2020 1:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	100,008,644	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	63,811,267	0	0	0	4.00
5.00	Other receivable	5,618,533	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	7,629,401	0	0	0	7.00
8.00	Prepaid expenses	1,088,074	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)	178,155,919	0	0	0	11.00
FIXED ASSETS						
12.00	Land	9,615,392	0	0	0	12.00
13.00	Land improvements	2,991,433	0	0	0	13.00
14.00	Accumulated depreciation	-2,324,029	0	0	0	14.00
15.00	Buildings	128,016,172	0	0	0	15.00
16.00	Accumulated depreciation	-53,223,010	0	0	0	16.00
17.00	Leasehold improvements	3,412,435	0	0	0	17.00
18.00	Accumulated depreciation	-2,221,976	0	0	0	18.00
19.00	Fixed equipment	19,035,398	0	0	0	19.00
20.00	Accumulated depreciation	-4,981,921	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	93,249,326	0	0	0	23.00
24.00	Accumulated depreciation	-62,777,492	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)	130,791,728	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,422,201	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	13,246,119	2,286,869	138,956	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,668,320	2,286,869	138,956	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	325,615,967	2,286,869	138,956	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	29,053,849	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,723,534	0	0	0	38.00
39.00	Payroll taxes payable	235,576	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,591,194	0	0	0	40.00
41.00	Deferred income	-541,401	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	20,300,173	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	60,362,925	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	29,964,403	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,964,403	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	90,327,328	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	235,288,639				52.00
53.00	Specific purpose fund		2,286,869			53.00
54.00	Donor created - endowment fund balance - restricted			138,956		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)	235,288,639	2,286,869	138,956	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	325,615,967	2,286,869	138,956	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-0104

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

Worksheet G-1

Date/Time Prepared:
8/27/2020 1:44 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		213,830,948		2,242,382		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		55,896,985				2.00
3.00	Total (sum of line 1 and line 2)		269,727,933		2,242,382		3.00
4.00	Additions (credit adjustments)	61,018		97,014		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)		61,018		97,014		10.00
11.00	Subtotal (line 3 plus line 10)		269,788,951		2,339,396		11.00
12.00	Deductions (debit adjustments)	0		52,527		0	12.00
13.00	CORPORATE OFFICE	34,500,312		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)		34,500,312		52,527		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		235,288,639		2,286,869		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	138,956		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)	138,956		0			3.00
4.00	Additions (credit adjustments)		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)	138,956		0			11.00
12.00	Deductions (debit adjustments)		0				12.00
13.00	CORPORATE OFFICE		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)	138,956		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-0104

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/27/2020 1:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	157,251,651		157,251,651	1.00
2.00	SUBPROVIDER - IPF	7,786,032		7,786,032	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	3,585,910		3,585,910	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	168,623,593		168,623,593	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	45,824,243		45,824,243	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)	45,824,243		45,824,243	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	214,447,836		214,447,836	17.00
18.00	Ancillary services	448,017,088	713,200,634	1,161,217,722	18.00
19.00	Outpatient services	46,866,652	126,963,598	173,830,250	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	NON-REIMBURSABLE PROFESSIONAL FEES	3,767,293	5,171,534	8,938,827	27.00
27.01	EMPLOYEE HEALTH INSURANCE	11,746,018	30,099,084	41,845,102	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	724,844,887	875,434,850	1,600,279,737	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		439,235,045		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		439,235,045		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-0104

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

Worksheet G-3

Date/Time Prepared:
8/27/2020 1:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,600,279,737	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,157,241,734	2.00
3.00	Net patient revenues (line 1 minus line 2)	443,038,003	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	439,235,045	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,802,958	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	417,505	6.00
7.00	Income from investments	569,002	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	12,156	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,764,282	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	44,038,446	17.00
18.00	Revenue from sale of medical records and abstracts	29	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	448,625	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	4,843,982	24.00
25.00	Total other income (sum of lines 6-24)	52,094,027	25.00
26.00	Total (line 5 plus line 25)	55,896,985	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)	55,896,985	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 26-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/27/2020 1:44 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,138,892	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		38,058	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		212.88	3.00
4.00	Number of interns & residents (see instructions)		13.80	4.00
5.00	Indirect medical education percentage (see instructions)		1.85	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		76,570	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		5.72	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		34.93	8.00
9.00	Sum of lines 7 and 8		40.65	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.58	10.00
11.00	Disproportionate share adjustment (see instructions)		355,117	11.00
12.00	Total prospective capital payments (see instructions)		4,608,637	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00