

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 1/28/2021 1:27 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		Date: 1/28/2021 Time: 1:27 pm
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MERCY HOSPITAL & MEDICAL CENTER (14-0158) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
 Officer or Administrator of Provider(s)

 Title

 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-1,613,529	-163,221	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	11,846	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-1,601,683	-163,221	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 1:27 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2525 SOUTH MICHIGAN AVENUE			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60616-2477		County: COOK		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MERCY HOSPITAL & MEDICAL CENTER	140158	16974	1	07/01/1966	N	P	O
4.00	Subprovider - IPF		MERCY HOSPITAL & MEDICAL CENTER	14S158	16974	4	07/01/1984	N	P	O
5.00	Subprovider - IRF		MERCY HOSPITAL & MEDICAL CENTER	14T158	16974	5	07/01/1984	N	P	O
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
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									
17.10	Hospital-Based (CORF) I									
17.20	Hospital-Based (OPT) I									
17.30	Hospital-Based (OOT) I									
17.40	Hospital-Based (OSP) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020		
21.00	Type of Control (see instructions)						1			
							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			
22.01	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			
22.02	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			
22.03	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		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			

Worksheet S-2
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

MCRIF32 - 16.6.170.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 1:27 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.	N					60.00		
		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			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
		1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 1:27 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		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.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 1:27 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
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.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	317,483	5,565,210	3,075,254118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
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	HB1432	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 1:27 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: TRINITY HEALTH	Contractor's Name: WPS		Contractor's Number: 05101						
142.00	Street: 20555 VICTOR PKWY	PO Box:								
143.00	City: LIVONIA	State: MI		Zip Code:		48152				
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						Y	N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N		146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N				155.00	
156.00	Subprovider - IPF	N	N	N	N				156.00	
157.00	Subprovider - IRF	N	N	N	N				157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF	N	N	N	N				159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N				160.00	
161.00	CMHC		N	N	N				161.00	
161.10	CORF		N	N	N				161.10	
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N				161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N				161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N				161.40	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part II Date/Time Prepared: 1/28/2021 1:27 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	10/31/2017	N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			Y		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	CADDICK		41.00
42.00	Enter the employer/company name of the cost report preparer.	SRGROUPLLC.COM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	708 466-7240	MICHAEL.CADDICK@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/28/2021 1:27 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.	VICE PRESIDENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 1:27 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	168	61,320	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)		168	61,320	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	6	2,190	0.00	0	9.00
9.01 NURSERY INTENSIVE CARE CENTER	32.01	15	5,475	0.00	0	9.01
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)		203	74,095	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	39	14,235		0	16.00
17.00 SUBPROVIDER - IRF	41.00	16	5,840		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		258				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,133	2,948	30,151			1.00
2.00	HMO and other (see instructions)	6,850	10,662				2.00
3.00	HMO IPF Subprovider	699	2,633				3.00
4.00	HMO IRF Subprovider	343	418				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,133	2,948	30,151			7.00
8.00	INTENSIVE CARE UNIT	1,525	470	4,809			8.00
9.00	CORONARY CARE UNIT	295	121	1,235			9.00
9.01	NURSERY INTENSIVE CARE CENTER	0	573	1,041			9.01
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		1,779	3,234			13.00
14.00	Total (see instructions)	10,953	5,891	40,470	108.53	1,248.23	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	928	1,095	6,930	0.00	31.50	16.00
17.00	SUBPROVIDER - IRF	1,427	125	2,725	0.00	14.70	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				108.53	1,294.43	27.00
28.00	Observation Bed Days		0	6,787			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			32			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	441	564			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 1:27 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	1,974	1,074	9,053	1.00
2.00 HMO and other (see instructions)			1,249	2,721		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				49		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
9.01 NURSERY INTENSIVE CARE CENTER						9.01
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	1,974	1,074	9,053	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	139	245	1,272	16.00
17.00 SUBPROVIDER - IRF	0.00	0	138	14	259	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/28/2021 1:27 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	105,851,058	0	105,851,058	2,854,245.00	37.09
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		377,886	0	377,886	1,825.00	207.06
4.01	Physicians - Part A - Teaching		1,020,151	0	1,020,151	7,686.00	132.73
5.00	Physician and Non Physician-Part B		16,142,324	0	16,142,324	116,750.00	138.26
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	5,612,664	-1,241,199	4,371,465	161,824.00	27.01
7.01	Contracted interns and residents (in an approved programs)		1,938,706	0	1,938,706	63,232.00	30.66
8.00	Home office and/or related organization personnel		2,662,763	0	2,662,763	8,320.00	320.04
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,109,766	0	5,109,766	154,263.00	33.12
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		9,494,853	0	9,494,853	185,194.00	51.27
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		0	0	0	0.00	0.00
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		7,533,447	0	7,533,447	138,499.00	54.39
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)		19,390,301	0	19,390,301		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,256,876	0	1,256,876		
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		43,034	0	43,034		
22.01	Physician Part A - Teaching		133,990	0	133,990		
23.00	Physician Part B		2,083,964	0	2,083,964		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		1,075,273	0	1,075,273		
25.50	Home office wage-related (core)		1,982,156	0	1,982,156		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/28/2021 1:27 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	1,257,897	0	1,257,897	17,109.00	73.52	26.00
27.00	Administrative & General	5.00	14,437,173	0	14,437,173	384,963.00	37.50	27.00
28.00	Administrative & General under contract (see inst.)		1,508,707	0	1,508,707	10,294.00	146.56	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,171,057	0	2,171,057	72,510.00	29.94	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,866,412	0	1,866,412	117,978.00	15.82	32.00
33.00	Housekeeping under contract (see instructions)		656,197	0	656,197	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,298,394	0	1,298,394	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,060,198	0	2,060,198	40,070.00	51.41	38.00
39.00	Central Services and Supply	14.00	675,444	0	675,444	32,893.00	20.53	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,480,813	0	1,480,813	51,166.00	28.94	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
1/28/2021 1:27 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)	81,937,748	1,241,199	83,178,947	2,506,727.00	33.18	1.00
2.00	Excluded area salaries (see instructions)	5,109,766	0	5,109,766	154,263.00	33.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)	76,827,982	1,241,199	78,069,181	2,352,464.00	33.19	3.00
4.00	Subtotal other wages & related costs (see inst.)	17,028,300	0	17,028,300	323,693.00	52.61	4.00
5.00	Subtotal wage-related costs (see inst.)	21,415,491	0	21,415,491	0.00	27.43	5.00
6.00	Total (sum of lines 3 thru 5)	115,271,773	1,241,199	116,512,972	2,676,157.00	43.54	6.00
7.00	Total overhead cost (see instructions)	27,412,292	0	27,412,292	726,983.00	37.71	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
1/28/2021 1:27 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	4,513,533	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	46,896	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)	9,598,807	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	133,237	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	108,511	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)	748,025	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,084,225	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	7,547,682	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	90,389	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	112,130	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	23,983,435	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
1/28/2021 1:27 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	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		MERCY HOSPITAL & MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 1/28/2021 1:27 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)			0.342398	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			108,996,708	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			208,592,062	6.00
7.00	Medicaid cost (line 1 times line 6)			71,421,505	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	7,258,684	1,252,982	8,511,666	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,485,359	1,252,982	3,738,341	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)	2,485,359	1,252,982	3,738,341	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)			16,025,410	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			613,164	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			943,330	27.01
28.00	Non-Medicare bad debt expense (see instructions)			15,082,080	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			5,494,240	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			9,232,581	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,232,581	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		135,420	135,420	5,003,597	5,139,017	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		564,563	564,563	0	564,563	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,257,897	24,732,491	25,990,388	0	25,990,388	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,437,173	55,536,278	69,973,451	-5,003,597	64,969,854	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,171,057	13,120,564	15,291,621	0	15,291,621	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,144,081	1,144,081	0	1,144,081	8.00
9.00	00900	HOUSEKEEPING	1,866,412	1,147,238	3,013,650	0	3,013,650	9.00
10.00	01000	DIETARY	0	3,689,621	3,689,621	-1,404,064	2,285,557	10.00
11.00	01100	CAFETERIA	0	0	0	1,404,064	1,404,064	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,060,198	131,226	2,191,424	0	2,191,424	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	675,444	666,616	1,342,060	0	1,342,060	14.00
15.00	01500	PHARMACY	0	17,503,402	17,503,402	0	17,503,402	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,480,813	647,724	2,128,537	0	2,128,537	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	5,612,664	3,393,843	9,006,507	-1,241,199	7,765,308	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	165,062	34,020	199,082	1,241,199	1,440,281	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,447,099	2,649,444	20,096,543	0	20,096,543	30.00
31.00	03100	INTENSIVE CARE UNIT	5,717,105	646,027	6,363,132	0	6,363,132	31.00
32.00	03200	CORONARY CARE UNIT	694,347	65,413	759,760	0	759,760	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	0	1,282,704	1,282,704	32.01
40.00	04000	SUBPROVIDER - IPF	2,357,558	1,770,982	4,128,540	0	4,128,540	40.00
41.00	04100	SUBPROVIDER - IRF	820,360	1,048,467	1,868,827	0	1,868,827	41.00
43.00	04300	NURSERY	1,854,284	602,595	2,456,879	-1,282,704	1,174,175	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,947,053	5,249,505	8,196,558	-3,272,137	4,924,421	50.00
50.01	03340	GI LAB	461,764	367,223	828,987	0	828,987	50.01
51.00	05100	RECOVERY ROOM	531,085	21,670	552,755	0	552,755	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,541,437	630,351	3,171,788	0	3,171,788	52.00
53.00	05300	ANESTHESIOLOGY	3,010,334	888,164	3,898,498	0	3,898,498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,456,924	885,919	4,342,843	-660,127	3,682,716	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	559,968	1,090,104	1,650,072	0	1,650,072	55.00
56.00	05600	RADIOISOTOPE	265,139	331,698	596,837	0	596,837	56.00
57.00	05700	CT SCAN	760,608	154,290	914,898	0	914,898	57.00
58.00	05800	MRI	217,792	86,022	303,814	0	303,814	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,023,016	3,489,383	5,512,399	-1,327,410	4,184,989	59.00
60.00	06000	LABORATORY	4,011,464	4,877,933	8,889,397	0	8,889,397	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,398,733	326,973	1,725,706	-109,433	1,616,273	65.00
66.00	06600	PHYSICAL THERAPY	968,000	6,482	974,482	0	974,482	66.00
67.00	06700	OCCUPATIONAL THERAPY	521,630	10,891	532,521	0	532,521	67.00
68.00	06800	SPEECH PATHOLOGY	316,797	4,349	321,146	0	321,146	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	42,865	1,256	44,121	0	44,121	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,203,012	2,203,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,166,095	3,166,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	820,759	820,759	0	820,759	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	183,338	15,054	198,392	0	198,392	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	253,271	44,676	297,947	0	297,947	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	914,865	243,693	1,158,558	0	1,158,558	76.06
76.07	03958	SLEEP LAB	0	514,623	514,623	0	514,623	76.07
76.08	03640	UROLOGY	53,611	271	53,882	0	53,882	76.08
76.09	03959	ADDP OP	90,242	480	90,722	0	90,722	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	104,636	45,305	149,941	0	149,941	76.11
76.12	03961	MENTAL HEALTH CENTER	767,698	18,967	786,665	0	786,665	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	271,251	10,476	281,727	0	281,727	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 MERCY CLINICS	9,327,573	4,676,049	14,003,622	0	14,003,622	90.01
90.02	09002 MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	9,300,643	2,620,310	11,920,953	0	11,920,953	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	103,919,210	156,662,891	260,582,101	0	260,582,101	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100 RESEARCH	228,516	36,627	265,143	0	265,143	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,556,915	5,441,414	6,998,329	0	6,998,329	192.00
192.01	19201 DNBAR CLINIC	54,586	101,818	156,404	0	156,404	192.01
192.02	19202 PHILLIPS HEALTH	53,024	140,114	193,138	0	193,138	192.02
192.03	19204 OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205 VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203 DOCTORS OFFICE	38,807	16,177	54,984	0	54,984	192.05
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00	TOTAL (SUM OF LINES 118 through 199)	105,851,058	162,399,041	268,250,099	0	268,250,099	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
1/28/2021 1:27 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	-239,419	4,899,598	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	564,563	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,810,142	24,180,246	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-16,748,195	48,221,659	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-306,868	14,984,753	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,144,081	8.00
9.00	00900	HOUSEKEEPING	0	3,013,650	9.00
10.00	01000	DIETARY	0	2,285,557	10.00
11.00	01100	CAFETERIA	-642,278	761,786	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	2,191,424	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,342,060	14.00
15.00	01500	PHARMACY	-331	17,503,071	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-835	2,127,702	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-68,358	7,696,950	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-1,228,041	212,240	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,741,689	17,354,854	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,678,072	4,685,060	31.00
32.00	03200	CORONARY CARE UNIT	0	759,760	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	1,282,704	32.01
40.00	04000	SUBPROVIDER - IPF	-462,224	3,666,316	40.00
41.00	04100	SUBPROVIDER - IRF	0	1,868,827	41.00
43.00	04300	NURSERY	-479,952	694,223	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-450,272	4,474,149	50.00
50.01	03340	GI LAB	-3,831	825,156	50.01
51.00	05100	RECOVERY ROOM	0	552,755	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,171,788	52.00
53.00	05300	ANESTHESIOLOGY	-3,668,258	230,240	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-808,243	2,874,473	54.00
54.01	05401	MRI CENTER	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-931,525	718,547	55.00
56.00	05600	RADIOISOTOPE	0	596,837	56.00
57.00	05700	CT SCAN	0	914,898	57.00
58.00	05800	MRI	0	303,814	58.00
59.00	05900	CARDIAC CATHETERIZATION	-2,127,572	2,057,417	59.00
60.00	06000	LABORATORY	-208,942	8,680,455	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,616,273	65.00
66.00	06600	PHYSICAL THERAPY	0	974,482	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	532,521	67.00
68.00	06800	SPEECH PATHOLOGY	0	321,146	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	44,121	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,203,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,166,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	820,759	74.00
76.00	03951	EMG	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	198,392	76.02
76.03	03954	MERCY ENT	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	297,947	76.04
76.05	03956	CARDIAC REHAB	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	-796,644	361,914	76.06
76.07	03958	SLEEP LAB	0	514,623	76.07
76.08	03640	UROLOGY	0	53,882	76.08
76.09	03959	ADDP OP	0	90,722	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	149,941	76.11
76.12	03961	MENTAL HEALTH CENTER	-399,215	387,450	76.12
76.13	03650	VEIN CLINIC	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	-69,073	212,654	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	MERCY CLINICS	-6,300,357	7,703,265	90.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
90.02	09002	MERCY CLINIC STATE ST	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	90.03
91.00	09100	EMERGENCY	-4,831,222	7,089,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-47,001,558	213,580,543	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	0	265,143	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,998,329	192.00
192.01	19201	DNBAR CLINIC	0	156,404	192.01
192.02	19202	PHILLIPS HEALTH	0	193,138	192.02
192.03	19204	OTHER HOME HEALTH	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	54,984	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-47,001,558	221,248,541	200.00

RECLASSIFICATIONS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
1/28/2021 1:27 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - PROPERTY INSURANCE					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	158,000		
	TOTALS		0	158,000		
B - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,203,012	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	2,203,012		
C - CAFETERIA COSTS						
1.00	CAFETERIA	11.00	0	1,404,064	1.00	
	TOTALS		0	1,404,064		
D - SPECIAL CARE NURSERY						
1.00	NURSERY INTENSIVE CARE CENTER	32.01	1,203,129	79,575	1.00	
	TOTALS		1,203,129	79,575		
E - IMPLANT SUPPLIES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,166,095	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	3,166,095		
F - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,845,597	1.00	
	TOTALS		0	4,845,597		
G - INTERNS RESIDENTS OTHER COSTS						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	1,241,199	0	1.00	
	TOTALS		1,241,199	0		
500.00	Grand Total: Increases		2,444,328	11,856,343	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
1/28/2021 1:27 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	158,000	9	1.00
	TOTALS		0	158,000		
B - MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	940,418	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	660,127	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	493,034	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	109,433	0	4.00
	TOTALS		0	2,203,012		
C - CAFETERIA COSTS						
1.00	DIETARY	10.00	0	1,404,064	0	1.00
	TOTALS		0	1,404,064		
D - SPECIAL CARE NURSERY						
1.00	NURSERY	43.00	1,203,129	79,575	0	1.00
	TOTALS		1,203,129	79,575		
E - IMPLANT SUPPLIES						
1.00	OPERATING ROOM	50.00	0	2,331,719	0	1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	834,376	0	2.00
	TOTALS		0	3,166,095		
F - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,845,597	9	1.00
	TOTALS		0	4,845,597		
G - INTERNS RESIDENTS OTHER COSTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,241,199	0	0	1.00
	TOTALS		1,241,199	0		
500.00	Grand Total: Decreases		2,444,328	11,856,343		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
1/28/2021 1:27 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	21,700,000	0	0	0	0	1.00	
2.00	Land Improvements	7,149,620	0	0	0	3,207,597	2.00	
3.00	Buildings and Fixtures	33,281,201	3,455,000	0	3,455,000	32,318,112	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	33,281,201	6,274,331	0	6,274,331	32,860,889	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	95,412,022	9,729,331	0	9,729,331	68,386,598	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	95,412,022	9,729,331	0	9,729,331	68,386,598	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	21,700,000	0				1.00	
2.00	Land Improvements	3,942,023	0				2.00	
3.00	Buildings and Fixtures	4,418,089	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	6,694,643	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	36,754,755	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	36,754,755	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	135,420	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	564,563	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	699,983	0	0	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	135,420				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	564,563				2.00
3.00	Total (sum of lines 1-2)	0	699,983				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,899,598	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	564,563	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,464,161	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	0	0	0	0	4,899,598	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	564,563	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	5,464,161	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-138,269	CAP REL COSTS-BLDG & FIXT	1.00	9	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)	B	-91,076	CAP REL COSTS-BLDG & FIXT	1.00	9	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	-28,585,550			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	409,820			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-642,278	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-331	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-21	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
1/28/2021 1:27 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.60 MARKETING NON ALLOW BEN	A	-19,523	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.60
33.61 MARKETING COSTS	A	-484,998	ADMINISTRATIVE & GENERAL	5.00	0	33.61
33.62 MISC REVENUE	B	-360	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.62
33.73 MISCELLANEOUS INCOME	B	-279,040	ADMINISTRATIVE & GENERAL	5.00	0	33.73
33.78 MISCELLANEOUS INCOME	B	-98,419	RADIOLOGY-DIAGNOSTIC	54.00	0	33.78
33.79 REFERRAL LAB REVENUE	B	-207,976	LABORATORY	60.00	0	33.79
33.82 MERCYWORKS ADMIN COSTS	A	-182,372	ADMINISTRATIVE & GENERAL	5.00	0	33.82
33.88 PROPERTY TAXES	A	-194,802	ADMINISTRATIVE & GENERAL	5.00	0	33.88
33.92 OTHER REVENUE	B	-528	ADULTS & PEDIATRICS	30.00	0	33.92
33.93 OTHER REVENUE	B	-53,900	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.93
33.94 OTHER REVENUE	B	-68,358	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1	33.94
33.95 PHYSICIAN PART B BENEFITS	A	-1,390,534	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.95
33.97 OTHER REVENUE	B	-14,691	OPERATION OF PLANT	7.00	0	33.97
33.98 MISC REVENUE	B	-11,235	CARDIAC REHABILITATION	76.97	0	33.98
33.99 LOBBYING COSTS	B	-50,000	ADMINISTRATIVE & GENERAL	5.00	0	33.99
34.00 OTHER REVENUE	B	-45,126	MERCY CLINICS	90.01	0	34.00
35.00 LEASE REVENUE	B	-207,403	MERCY CLINICS	90.01	0	35.00
38.00 PROPERTY TAXES	A	-110,000	MERCY CLINICS	90.01	0	38.00
39.00 OCCUPATIONAL MEDICINE ADMIN	A	-42,738	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 HOSPICE COSTS	A	-42,454	ADULTS & PEDIATRICS	30.00	0	40.00
41.00 IMPAIRMENT EXPENSES	A	-2,973,677	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00 MEDICAID ASSESSMENT	A	-11,475,719	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-47,001,558				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
1/28/2021 1:27 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	147,926	158,000	1.00
2.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	1,167,468	1,275,626	2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	726,959	1,018,526	3.00
3.01		5.00	ADMINISTRATIVE & GENERAL	8,957,947	6,537,699	3.01
3.02		5.00	ADMINISTRATIVE & GENERAL	397,633	1,435,703	3.02
3.03		5.00	ADMINISTRATIVE & GENERAL	17,695,795	17,966,177	3.03
3.04		7.00	OPERATION OF PLANT	3,153,797	3,445,974	3.04
4.00		0.00		0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			32,247,525	31,837,705	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	SISTERS OF MERCY	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
1/28/2021 1:27 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	-10,074	9		1.00
2.00	-108,158	0		2.00
3.00	-291,567	0		3.00
3.01	2,420,248	0		3.01
3.02	-1,038,070	0		3.02
3.03	-270,382	0		3.03
3.04	-292,177	0		3.04
4.00	0	0		4.00
5.00	409,820			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	RELIGIOUS ORDER		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
1/28/2021 1:27 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	AGGREGATE-ADMINISTRATIVE & GENERAL	2,304,945	2,127,702	177,243	177,200	1,506	1.00
2.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	2,177	0	2,177	177,200	16	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	1,828,929	808,778	1,020,151	177,200	7,686	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,698,707	0	0	0	0	4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	1,678,072	0	0	0	0	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	462,224	0	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	450,272	0	0	0	0	7.00
8.00	50.01	AGGREGATE-GI LAB	3,831	3,831	0	0	0	8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	3,668,258	0	0	0	0	9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	709,824	709,824	0	0	0	10.00
11.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	931,525	931,525	0	0	0	11.00
12.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	2,143,844	2,012,760	131,084	177,200	191	12.00
13.00	90.01	AGGREGATE-MERCY CLINICS	5,937,828	5,937,828	0	0	0	13.00
14.00	43.00	AGGREGATE-NURSERY	479,952	479,952	0	0	0	14.00
15.00	60.00	AGGREGATE-LABORATORY	966	966	0	0	0	15.00
16.00	76.06	AGGREGATE-PRE-BIRTH CENTER	796,644	796,644	0	0	0	16.00
17.00	76.12	AGGREGATE-MENTAL HEALTH CENTER	399,215	0	0	0	0	17.00
18.00	76.97	AGGREGATE-CARDIAC REHABILITATION	67,380	0	67,380	177,200	112	18.00
19.00	91.00	AGGREGATE-EMERGENCY	4,831,222	0	0	0	0	19.00
20.00	0.00	AGGREGATE-	0	0	0	0	0	20.00
200.00			29,395,815	13,809,810	1,398,035		9,511	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	128,300	6,415	0	0	0	1.00
2.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	1,363	68	0	0	0	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	654,788	32,739	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	7.00
8.00	50.01	AGGREGATE-GI LAB	0	0	0	0	0	8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	10.00
11.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	0	0	11.00
12.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	16,272	814	0	0	0	12.00
13.00	90.01	AGGREGATE-MERCY CLINICS	0	0	0	0	0	13.00
14.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	14.00
15.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	15.00
16.00	76.06	AGGREGATE-PRE-BIRTH CENTER	0	0	0	0	0	16.00
17.00	76.12	AGGREGATE-MENTAL HEALTH CENTER	0	0	0	0	0	17.00
18.00	76.97	AGGREGATE-CARDIAC REHABILITATION	9,542	477	0	0	0	18.00
19.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	19.00
20.00	0.00	AGGREGATE-	0	0	0	0	0	20.00
200.00			810,265	40,513	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	128,300	48,943	2,176,645		1.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
1/28/2021 1:27 pm

	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		
2.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	1,363	814	814		2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	654,788	365,363	1,174,141		3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,698,707		4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	1,678,072		5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	462,224		6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	450,272		7.00
8.00	50.01	AGGREGATE-GI LAB	0	0	0	3,831		8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	3,668,258		9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	709,824		10.00
11.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	931,525		11.00
12.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	16,272	114,812	2,127,572		12.00
13.00	90.01	AGGREGATE-MERCY CLINICS	0	0	0	5,937,828		13.00
14.00	43.00	AGGREGATE-NURSERY	0	0	0	479,952		14.00
15.00	60.00	AGGREGATE-LABORATORY	0	0	0	966		15.00
16.00	76.06	AGGREGATE-PRE-BIRTH CENTER	0	0	0	796,644		16.00
17.00	76.12	AGGREGATE-MENTAL HEALTH CENTER	0	0	0	399,215		17.00
18.00	76.97	AGGREGATE-CARDIAC REHABILITATION	0	9,542	57,838	57,838		18.00
19.00	91.00	AGGREGATE-EMERGENCY	0	0	0	4,831,222		19.00
20.00	0.00	AGGREGATE-	0	0	0	0		20.00
200.00			0	810,265	587,770	28,585,550		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,899,598	4,899,598			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	564,563		564,563		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	24,180,246	44,519	0	24,224,765	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,221,659	327,469	240,006	3,704,928	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	14,984,753	1,738,397	1,887	582,396	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,144,081	77,604	0	0	8.00
9.00	00900	HOUSEKEEPING	3,013,650	18,437	498	570,102	9.00
10.00	01000	DIETARY	2,285,557	86,151	1,105	0	10.00
11.00	01100	CAFETERIA	761,786	69,189	923	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,191,424	12,475	0	447,024	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,342,060	63,703	5,274	184,420	14.00
15.00	01500	PHARMACY	17,503,071	0	2,425	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,127,702	40,541	304	186,232	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	7,696,950	70,543	107	211,421	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	212,240	23,457	0	405,047	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,354,854	716,303	38,257	4,812,900	30.00
31.00	03100	INTENSIVE CARE UNIT	4,685,060	56,075	63,992	1,035,841	31.00
32.00	03200	CORONARY CARE UNIT	759,760	59,265	1,251	299,838	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	1,282,704	17,765	2,379	338,954	32.01
40.00	04000	SUBPROVIDER - IPF	3,666,316	109,919	81	587,071	40.00
41.00	04100	SUBPROVIDER - IRF	1,868,827	43,690	1,640	358,098	41.00
43.00	04300	NURSERY	694,223	10,375	3,146	233,603	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,474,149	264,226	10,858	1,020,996	50.00
50.01	03340	GI LAB	825,156	14,369	915	162,028	50.01
51.00	05100	RECOVERY ROOM	552,755	17,716	0	180,690	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,171,788	131,900	3,370	782,094	52.00
53.00	05300	ANESTHESIOLOGY	230,240	2,985	225	33,131	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,874,473	187,851	27,487	975,103	54.00
54.01	05401	MRI CENTER	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	718,547	4,872	1,350	119,722	55.00
56.00	05600	RADIOISOTOPE	596,837	17,773	105	96,889	56.00
57.00	05700	CT SCAN	914,898	4,101	9,910	245,749	57.00
58.00	05800	MRI	303,814	30,420	61,680	74,099	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,057,417	146,228	20,742	675,584	59.00
60.00	06000	LABORATORY	8,680,455	125,576	37,220	1,257,538	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,616,273	7,275	2,250	402,713	65.00
66.00	06600	PHYSICAL THERAPY	974,482	45,987	5,348	318,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	532,521	17,568	0	161,804	67.00
68.00	06800	SPEECH PATHOLOGY	321,146	13,598	0	81,225	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,121	17,256	0	16,288	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,203,012	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,166,095	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	820,759	7,283	0	0	74.00
76.00	03951	EMG	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	198,392	39,991	119	57,457	76.02
76.03	03954	MERCY ENT	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	297,947	5,594	2,341	60,607	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	361,914	0	0	89,536	76.06
76.07	03958	SLEEP LAB	514,623	0	0	0	76.07
76.08	03640	UROLOGY	53,882	7,308	240	26,982	76.08
76.09	03959	ADDP OP	90,722	0	0	33,824	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	11,933	0	0	76.10
76.11	03960	DIABETES TREATMENT	149,941	0	0	34,521	76.11
76.12	03961	MENTAL HEALTH CENTER	387,450	0	0	37,703	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	212,654	0	103	89,304	76.97

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	7,703,265	37,129	10,277	750,350	8,501,021	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	7,089,731	121,623	3,355	1,354,717	8,569,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,580,543	4,866,439	561,170	23,097,035	212,416,261	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	265,143	0	0	54,695	319,838	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,998,329	33,159	2,038	985,927	8,019,453	192.00
192.01	19201	DNBAR CLINIC	156,404	0	0	16,915	173,319	192.01
192.02	19202	PHILLIPS HEALTH	193,138	0	0	16,579	209,717	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	54,984	0	1,355	53,614	109,953	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	221,248,541	4,899,598	564,563	24,224,765	221,248,541	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,494,062					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	5,413,990	0	22,721,423			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	382,159	0	632,179	2,236,023		8.00
9.00	00900	HOUSEKEEPING	1,126,967	0	150,194	0	4,879,848	9.00
10.00	01000	DIETARY	742,247	0	701,797	0	156,099	10.00
11.00	01100	CAFETERIA	260,229	0	563,629	0	125,367	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	829,243	0	101,622	0	22,603	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	499,080	0	518,932	0	115,425	14.00
15.00	01500	PHARMACY	5,475,947	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	736,605	0	330,254	0	73,457	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,495,941	0	574,653	0	127,819	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	200,433	0	191,083	0	42,502	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,170,329	0	5,835,127	1,491,399	1,297,896	30.00
31.00	03100	INTENSIVE CARE UNIT	1,827,131	0	456,796	157,048	101,604	31.00
32.00	03200	CORONARY CARE UNIT	350,386	0	482,786	57,499	107,385	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	513,577	0	144,716	73,268	32,189	32.01
40.00	04000	SUBPROVIDER - IPF	1,364,924	0	895,420	289,965	199,166	40.00
41.00	04100	SUBPROVIDER - IRF	710,791	0	355,910	166,844	79,164	41.00
43.00	04300	NURSERY	0	0	84,518	0	18,799	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,805,003	0	2,152,428	0	478,759	50.00
50.01	03340	GI LAB	313,585	0	117,055	0	26,036	50.01
51.00	05100	RECOVERY ROOM	234,973	0	144,315	0	32,100	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,279,140	0	1,074,477	0	238,993	52.00
53.00	05300	ANESTHESIOLOGY	83,390	0	24,320	0	5,409	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,271,558	0	1,530,271	0	340,374	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	264,168	0	39,687	0	8,827	55.00
56.00	05600	RADIOISOTOPE	222,599	0	144,782	0	32,204	56.00
57.00	05700	CT SCAN	367,448	0	33,406	0	7,430	57.00
58.00	05800	MRI	147,026	0	247,807	0	55,119	58.00
59.00	05900	CARDIAC CATHETERIZATION	907,149	0	1,191,198	0	264,955	59.00
60.00	06000	LABORATORY	3,159,658	0	1,022,964	0	227,535	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	634,545	0	59,263	0	13,182	65.00
66.00	06600	PHYSICAL THERAPY	420,522	0	374,617	0	83,325	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,689	0	143,112	0	31,832	67.00
68.00	06800	SPEECH PATHOLOGY	130,121	0	110,775	0	24,639	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,295	0	140,573	0	31,267	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	689,131	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	990,396	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	259,022	0	59,329	0	13,196	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	92,580	0	325,777	0	72,462	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	114,643	0	45,566	0	10,135	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	141,219	0	0	0	0	76.06
76.07	03958	SLEEP LAB	160,981	0	0	0	0	76.07
76.08	03640	UROLOGY	27,656	0	59,530	0	13,241	76.08
76.09	03959	ADDP OP	38,960	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	3,733	0	97,212	0	21,623	76.10
76.11	03960	DIABETES TREATMENT	57,702	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	132,993	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	94,489	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	2,659,230	0	302,460	0	67,275	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,680,628	0	990,761	0	220,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,731,211	0	22,451,301	2,236,023	4,819,765	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	100,049	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,508,589	0	270,122	0	60,083	192.00
192.01	19201	DNBAR CLINIC	54,216	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	65,602	0	0	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	34,395	0	0	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	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)	52,494,062	0	22,721,423	2,236,023	4,879,848	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	3,972,956					10.00
11.00	01100	CAFETERIA	0	1,781,123				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	30,754	0	3,635,145		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,476	0	0	2,758,370	14.00
15.00	01500	PHARMACY	0	0	0	0	22,312	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,248	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	182,217	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	6	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,718,921	497,115	0	1,574,809	202,700	30.00
31.00	03100	INTENSIVE CARE UNIT	319,259	92,659	0	293,533	89,247	31.00
32.00	03200	CORONARY CARE UNIT	90,432	18,803	0	59,565	15,372	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	23,249	0	73,650	8,233	32.01
40.00	04000	SUBPROVIDER - IPF	567,475	60,291	0	190,996	2,239	40.00
41.00	04100	SUBPROVIDER - IRF	276,869	30,877	0	97,814	10,601	41.00
43.00	04300	NURSERY	0	13,831	0	43,816	5,674	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	80,313	0	254,422	283,041	50.00
50.01	03340	GI LAB	0	14,131	0	44,765	59,587	50.01
51.00	05100	RECOVERY ROOM	0	11,153	0	35,331	2,503	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	56,579	0	179,237	57,042	52.00
53.00	05300	ANESTHESIOLOGY	0	26,349	0	83,469	32,904	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	78,328	0	0	29,318	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,374	0	0	2,062	55.00
56.00	05600	RADIOISOTOPE	0	5,681	0	0	31,413	56.00
57.00	05700	CT SCAN	0	18,394	0	0	30,661	57.00
58.00	05800	MRI	0	4,541	0	0	1,507	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	46,615	0	147,670	3,258	59.00
60.00	06000	LABORATORY	0	112,569	0	0	509,875	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	35,967	0	113,940	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,795	0	0	1,176	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,994	0	0	1,300	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,408	0	0	234	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,863	0	0	191	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	445,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	768,950	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	4,100	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	6,166	0	0	748	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	5,470	0	17,329	1,004	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	8,904	0	0	1,095	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	2,237	0	0	28	76.08
76.09	03959	ADDP OP	0	2,215	0	0	4	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	2,409	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	16,062	0	0	26	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	6,795	0	0	464	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0	11,796	90.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	134,096	0	424,799	112,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,972,956	1,748,928	0	3,635,145	2,748,483	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	5,364	0	0	15	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,490	0	0	8,053	192.00
192.01	19201	DNBAR CLINIC	0	590	0	0	133	192.01
192.02	19202	PHILLIPS HEALTH	0	1,870	0	0	66	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	2,881	0	0	1,620	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	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)	3,972,956	1,781,123	0	3,635,145	2,758,370	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	23,003,755					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,533,343				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	478,308	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	98,024	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	18,624	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	46,544	0	0	0	32.01
40.00	04000	SUBPROVIDER - IPF	0	78,931	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	31,242	0	0	0	41.00
43.00	04300	NURSERY	0	25,191	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	104,730	0	0	0	50.00
50.01	03340	GI LAB	0	30,629	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	12,321	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,113	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	27,135	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	265,183	0	0	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	37,436	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	42,428	0	0	0	56.00
57.00	05700	CT SCAN	0	250,811	0	0	0	57.00
58.00	05800	MRI	0	49,948	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	185,768	0	0	0	59.00
60.00	06000	LABORATORY	0	632,570	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	87,148	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,370	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,081	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,454	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,007	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,555	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	43,329	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,003,755	364,327	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	10,055	0	0	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	5,535	0	0	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	5,547	0	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	20,675	0	0	0	76.06
76.07	03958	SLEEP LAB	0	10,462	0	0	0	76.07
76.08	03640	UROLOGY	0	53	0	0	0	76.08
76.09	03959	ADDP OP	0	1,247	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	6,045	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	680	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	3,150	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	6,289	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	3,867	0	0	0	90.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	393,531	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,003,755	3,533,343	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DNBAR CLINIC	0	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	0	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,003,755	3,533,343	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	11,359,651					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		1,074,768				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,573,390	621,926	0	51,384,234	-7,195,316	30.00
31.00	03100	INTENSIVE CARE UNIT	440,728	41,699	0	9,758,696	-482,427	31.00
32.00	03200	CORONARY CARE UNIT	165,879	15,694	0	2,502,539	-181,573	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	324,492	30,701	0	2,912,421	-355,193	32.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	8,012,794	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	4,032,367	0	41.00
43.00	04300	NURSERY	0	0	0	1,133,176	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	968,634	91,645	0	11,989,204	-1,060,279	50.00
50.01	03340	GI LAB	0	0	0	1,608,256	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	1,223,857	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,042,733	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	549,557	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,483,220	140,332	0	9,203,498	-1,623,552	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,207,045	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,190,711	0	56.00
57.00	05700	CT SCAN	0	0	0	1,882,808	0	57.00
58.00	05800	MRI	0	0	0	975,961	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	5,646,584	0	59.00
60.00	06000	LABORATORY	0	0	0	15,765,960	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,972,556	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,271,128	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,138,901	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	698,600	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	277,861	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,375,229	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,968,770	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,368,082	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,173,744	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	0	0	799,227	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	0	0	566,183	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	623,343	0	76.06
76.07	03958	SLEEP LAB	0	0	0	686,066	0	76.07
76.08	03640	UROLOGY	0	0	0	191,157	0	76.08
76.09	03959	ADDP OP	0	0	0	166,972	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	140,546	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	245,253	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	577,384	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	410,098	0	76.97

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	11,545,649	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,403,308	132,771	0	15,061,973	-1,536,079	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,359,651	1,074,768	0	209,281,123	-12,434,419	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	425,266	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	10,887,790	0	192.00
192.01	19201	DNBAR CLINIC	0	0	0	228,258	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	277,255	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	0	148,849	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	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)	11,359,651	1,074,768	0	221,248,541	-12,434,419	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
32.00	03200	CORONARY CARE UNIT	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	32.01
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
50.01	03340	GI LAB	50.01
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	MRI CENTER	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03951	EMG	76.00
76.01	03952	CARDIOVASCULAR LAB	76.01
76.02	03953	MERCY EYE CENTER	76.02
76.03	03954	MERCY ENT	76.03
76.04	03955	WOUND CARE CENTER	76.04
76.05	03956	CARDIAC REHAB	76.05
76.06	03957	PRE-BIRTH CENTER	76.06
76.07	03958	SLEEP LAB	76.07
76.08	03640	UROLOGY	76.08
76.09	03959	ADDP OP	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	76.10
76.11	03960	DIABETES TREATMENT	76.11
76.12	03961	MENTAL HEALTH CENTER	76.12
76.13	03650	VEIN CLINIC	76.13
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001	MERCY CLINICS	90.01
90.02	09002	MERCY CLINIC STATE ST	90.02
90.03	09003	MERCY CLINIC POLK ST	90.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			Total	
			26.00	
91.00	09100	EMERGENCY	13,525,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	93.99
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	196,846,704	118.00
NONREIMBURSABLE COST CENTERS				
191.00	19100	RESEARCH	425,266	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,887,790	192.00
192.01	19201	DNBAR CLINIC	228,258	192.01
192.02	19202	PHILLIPS HEALTH	277,255	192.02
192.03	19204	OTHER HOME HEALTH	0	192.03
192.04	19205	VITAS HOSPICE	0	192.04
192.05	19203	DOCTORS OFFICE	148,849	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951	SENIOR FRIENDS	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	208,814,122	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 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	44,519	0	44,519	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	97,105	327,469	240,006	664,580	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	86,780	1,738,397	1,887	1,827,064	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	77,604	0	77,604	8.00
9.00	00900	HOUSEKEEPING	8,175	18,437	498	27,110	9.00
10.00	01000	DIETARY	2,122	86,151	1,105	89,378	10.00
11.00	01100	CAFETERIA	1,771	69,189	923	71,883	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	12,475	0	12,475	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	481,336	63,703	5,274	550,313	14.00
15.00	01500	PHARMACY	0	0	2,425	2,425	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,541	304	40,845	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	70,543	107	70,650	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	23,457	0	23,457	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,843	716,303	38,257	780,403	30.00
31.00	03100	INTENSIVE CARE UNIT	5,299	56,075	63,992	125,366	31.00
32.00	03200	CORONARY CARE UNIT	686	59,265	1,251	61,202	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	17,765	2,379	20,144	32.01
40.00	04000	SUBPROVIDER - IPF	59	109,919	81	110,059	40.00
41.00	04100	SUBPROVIDER - IRF	2,716	43,690	1,640	48,046	41.00
43.00	04300	NURSERY	0	10,375	3,146	13,521	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,086,762	264,226	10,858	1,361,846	50.00
50.01	03340	GI LAB	149,230	14,369	915	164,514	50.01
51.00	05100	RECOVERY ROOM	5,670	17,716	0	23,386	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,345	131,900	3,370	144,615	52.00
53.00	05300	ANESTHESIOLOGY	0	2,985	225	3,210	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	187,851	27,487	215,338	54.00
54.01	05401	MRI CENTER	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,872	1,350	6,222	55.00
56.00	05600	RADIOISOTOPE	0	17,773	105	17,878	56.00
57.00	05700	CT SCAN	0	4,101	9,910	14,011	57.00
58.00	05800	MRI	924,190	30,420	61,680	1,016,290	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	146,228	20,742	166,970	59.00
60.00	06000	LABORATORY	0	125,576	37,220	162,796	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	44,839	7,275	2,250	54,364	65.00
66.00	06600	PHYSICAL THERAPY	0	45,987	5,348	51,335	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,568	0	17,568	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,598	0	13,598	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,256	0	17,256	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	7,283	0	7,283	74.00
76.00	03951	EMG	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	39,991	119	40,110	76.02
76.03	03954	MERCY ENT	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	484	5,594	2,341	8,419	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	76.07
76.08	03640	UROLOGY	0	7,308	240	7,548	76.08
76.09	03959	ADDP OP	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	11,933	0	11,933	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	103	103	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 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
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	420,557	37,129	10,277	467,963	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	121,623	3,355	124,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,352,969	4,866,439	561,170	8,780,578	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	101	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,159	2,038	1,813	192.00
192.01	19201	DNBAR CLINIC	0	0	0	31	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	30	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	1,355	99	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,352,969	4,899,598	564,563	8,817,130	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	671,392					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	69,247	0	1,897,382			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,888	0	52,791	135,283		8.00
9.00	00900	HOUSEKEEPING	14,414	0	12,542	0	55,114	9.00
10.00	01000	DIETARY	9,494	0	58,604	0	1,763	10.00
11.00	01100	CAFETERIA	3,328	0	47,067	0	1,416	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	10,606	0	8,486	0	255	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,383	0	43,334	0	1,304	14.00
15.00	01500	PHARMACY	70,039	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,421	0	27,578	0	830	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	31,924	0	47,987	0	1,444	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,564	0	15,957	0	480	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91,683	0	487,270	90,232	14,657	30.00
31.00	03100	INTENSIVE CARE UNIT	23,370	0	38,145	9,502	1,148	31.00
32.00	03200	CORONARY CARE UNIT	4,482	0	40,316	3,479	1,213	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	6,569	0	12,085	4,433	364	32.01
40.00	04000	SUBPROVIDER - IPF	17,458	0	74,773	17,543	2,249	40.00
41.00	04100	SUBPROVIDER - IRF	9,091	0	29,721	10,094	894	41.00
43.00	04300	NURSERY	0	0	7,058	0	212	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,087	0	179,741	0	5,407	50.00
50.01	03340	GI LAB	4,011	0	9,775	0	294	50.01
51.00	05100	RECOVERY ROOM	3,005	0	12,051	0	363	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,361	0	89,726	0	2,699	52.00
53.00	05300	ANESTHESIOLOGY	1,067	0	2,031	0	61	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,264	0	127,787	0	3,844	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,379	0	3,314	0	100	55.00
56.00	05600	RADIOISOTOPE	2,847	0	12,090	0	364	56.00
57.00	05700	CT SCAN	4,700	0	2,790	0	84	57.00
58.00	05800	MRI	1,881	0	20,693	0	623	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,603	0	99,473	0	2,992	59.00
60.00	06000	LABORATORY	40,413	0	85,424	0	2,570	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,116	0	4,949	0	149	65.00
66.00	06600	PHYSICAL THERAPY	5,379	0	31,283	0	941	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,848	0	11,951	0	360	67.00
68.00	06800	SPEECH PATHOLOGY	1,664	0	9,250	0	278	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	311	0	11,739	0	353	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,814	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,668	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	3,313	0	4,954	0	149	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	1,184	0	27,204	0	818	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	1,466	0	3,805	0	114	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	1,806	0	0	0	0	76.06
76.07	03958	SLEEP LAB	2,059	0	0	0	0	76.07
76.08	03640	UROLOGY	354	0	4,971	0	150	76.08
76.09	03959	ADDP OP	498	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	48	0	8,118	0	244	76.10
76.11	03960	DIABETES TREATMENT	738	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	1,701	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	1,209	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	34,013	0	25,257	0	760	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	34,286	0	82,735	0	2,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	636,054	0	1,874,825	135,283	54,435	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	1,280	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,086	0	22,557	0	679	192.00
192.01	19201	DNBAR CLINIC	693	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	839	0	0	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	440	0	0	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	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)	671,392	0	1,897,382	135,283	55,114	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	159,239					10.00
11.00	01100	CAFETERIA	0	123,694				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,136	0	34,780		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,047	0	0	603,720	14.00
15.00	01500	PHARMACY	0	0	0	0	4,884	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,656	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	12,654	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	108,976	34,526	0	15,068	44,365	30.00
31.00	03100	INTENSIVE CARE UNIT	12,796	6,435	0	2,808	19,533	31.00
32.00	03200	CORONARY CARE UNIT	3,625	1,306	0	570	3,365	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	1,615	0	705	1,802	32.01
40.00	04000	SUBPROVIDER - IPF	22,745	4,187	0	1,827	490	40.00
41.00	04100	SUBPROVIDER - IRF	11,097	2,144	0	936	2,320	41.00
43.00	04300	NURSERY	0	961	0	419	1,242	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,577	0	2,434	61,949	50.00
50.01	03340	GI LAB	0	981	0	428	13,042	50.01
51.00	05100	RECOVERY ROOM	0	775	0	338	548	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,929	0	1,715	12,485	52.00
53.00	05300	ANESTHESIOLOGY	0	1,830	0	799	7,202	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,440	0	0	6,417	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	720	0	0	451	55.00
56.00	05600	RADIOISOTOPE	0	395	0	0	6,875	56.00
57.00	05700	CT SCAN	0	1,277	0	0	6,711	57.00
58.00	05800	MRI	0	315	0	0	330	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,237	0	1,413	713	59.00
60.00	06000	LABORATORY	0	7,818	0	0	111,596	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,498	0	1,090	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,652	0	0	257	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	972	0	0	285	67.00
68.00	06800	SPEECH PATHOLOGY	0	445	0	0	51	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	129	0	0	42	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	97,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	168,295	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	897	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	428	0	0	164	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	380	0	166	220	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	618	0	0	240	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	155	0	0	6	76.08
76.09	03959	ADDP OP	0	154	0	0	1	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	167	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	1,115	0	0	6	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	472	0	0	102	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0	2,582	90.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	9,312	0	4,064	24,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,239	121,458	0	34,780	601,557	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	373	0	0	3	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,492	0	0	1,762	192.00
192.01	19201	DNBAR CLINIC	0	41	0	0	29	192.01
192.02	19202	PHILLIPS HEALTH	0	130	0	0	14	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	200	0	0	355	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	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)	159,239	123,694	0	34,780	603,720	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	77,348					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	81,672				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	11,051	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,265	0			31.00
32.00	03200	CORONARY CARE UNIT	0	430	0			32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	1,075	0			32.01
40.00	04000	SUBPROVIDER - IPF	0	1,824	0			40.00
41.00	04100	SUBPROVIDER - IRF	0	722	0			41.00
43.00	04300	NURSERY	0	582	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,420	0			50.00
50.01	03340	GI LAB	0	708	0			50.01
51.00	05100	RECOVERY ROOM	0	285	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,574	0			52.00
53.00	05300	ANESTHESIOLOGY	0	627	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,127	0			54.00
54.01	05401	MRI CENTER	0	0	0			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	865	0			55.00
56.00	05600	RADIOISOTOPE	0	980	0			56.00
57.00	05700	CT SCAN	0	5,795	0			57.00
58.00	05800	MRI	0	1,154	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,292	0			59.00
60.00	06000	LABORATORY	0	14,649	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	2,014	0			65.00
66.00	06600	PHYSICAL THERAPY	0	540	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	325	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	242	0			68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	46	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	868	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,001	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,348	8,418	0			73.00
74.00	07400	RENAL DIALYSIS	0	232	0			74.00
76.00	03951	EMG	0	0	0			76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0			76.01
76.02	03953	MERCY EYE CENTER	0	128	0			76.02
76.03	03954	MERCY ENT	0	0	0			76.03
76.04	03955	WOUND CARE CENTER	0	128	0			76.04
76.05	03956	CARDIAC REHAB	0	0	0			76.05
76.06	03957	PRE-BIRTH CENTER	0	478	0			76.06
76.07	03958	SLEEP LAB	0	242	0			76.07
76.08	03640	UROLOGY	0	1	0			76.08
76.09	03959	ADDP OP	0	29	0			76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	140	0			76.10
76.11	03960	DIABETES TREATMENT	0	16	0			76.11
76.12	03961	MENTAL HEALTH CENTER	0	73	0			76.12
76.13	03650	VEIN CLINIC	0	0	0			76.13
76.97	07697	CARDIAC REHABILITATION	0	145	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	89	0			90.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
90.02	09002	MERCY CLINIC STATE ST	0	0	0			90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0			90.03
91.00	09100	EMERGENCY	0	9,092	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,348	81,672	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	DNBAR CLINIC	0	0	0			192.01
192.02	19202	PHILLIPS HEALTH	0	0	0			192.02
192.03	19204	OTHER HOME HEALTH	0	0	0			192.03
192.04	19205	VITAS HOSPICE	0	0	0			192.04
192.05	19203	DOCTORS OFFICE	0	0	0			192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.00
194.01	07951	SENIOR FRIENDS	0	0	0			194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	77,348	81,672	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	165,048					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		43,204				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,687,059	0	30.00
31.00	03100	INTENSIVE CARE UNIT				243,273	0	31.00
32.00	03200	CORONARY CARE UNIT				120,539	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER				49,415	0	32.01
40.00	04000	SUBPROVIDER - IPF				254,234	0	40.00
41.00	04100	SUBPROVIDER - IRF				115,723	0	41.00
43.00	04300	NURSERY				24,425	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				1,644,338	0	50.00
50.01	03340	GI LAB				194,051	0	50.01
51.00	05100	RECOVERY ROOM				41,083	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				274,542	0	52.00
53.00	05300	ANESTHESIOLOGY				16,888	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				383,010	0	54.00
54.01	05401	MRI CENTER				0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC				15,271	0	55.00
56.00	05600	RADIOISOTOPE				41,607	0	56.00
57.00	05700	CT SCAN				35,820	0	57.00
58.00	05800	MRI				1,041,422	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				291,935	0	59.00
60.00	06000	LABORATORY				427,578	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				73,920	0	65.00
66.00	06600	PHYSICAL THERAPY				91,973	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				34,607	0	67.00
68.00	06800	SPEECH PATHOLOGY				25,677	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY				29,906	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				107,195	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				181,964	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				85,766	0	73.00
74.00	07400	RENAL DIALYSIS				16,828	0	74.00
76.00	03951	EMG				0	0	76.00
76.01	03952	CARDIOVASCULAR LAB				0	0	76.01
76.02	03953	MERCY EYE CENTER				70,142	0	76.02
76.03	03954	MERCY ENT				0	0	76.03
76.04	03955	WOUND CARE CENTER				14,809	0	76.04
76.05	03956	CARDIAC REHAB				0	0	76.05
76.06	03957	PRE-BIRTH CENTER				3,307	0	76.06
76.07	03958	SLEEP LAB				2,301	0	76.07
76.08	03640	UROLOGY				13,235	0	76.08
76.09	03959	ADDP OP				744	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL				20,483	0	76.10
76.11	03960	DIABETES TREATMENT				984	0	76.11
76.12	03961	MENTAL HEALTH CENTER				2,964	0	76.12
76.13	03650	VEIN CLINIC				0	0	76.13
76.97	07697	CARDIAC REHABILITATION				2,195	0	76.97

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00		23.00	24.00	25.00
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS				532,044	0	90.01
90.02	09002	MERCY CLINIC STATE ST				0	0	90.02
90.03	09003	MERCY CLINIC POLK ST				0	0	90.03
91.00	09100	EMERGENCY				294,022	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	8,507,279	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH				1,757	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				95,586	0	192.00
192.01	19201	DNBAR CLINIC				794	0	192.01
192.02	19202	PHILLIPS HEALTH				1,013	0	192.02
192.03	19204	OTHER HOME HEALTH				0	0	192.03
192.04	19205	VITAS HOSPICE				0	0	192.04
192.05	19203	DOCTORS OFFICE				2,449	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS				0	0	194.00
194.01	07951	SENIOR FRIENDS				0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS				0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS				0	0	194.03
200.00		Cross Foot Adjustments	165,048	43,204	0	208,252	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	165,048	43,204	0	8,817,130	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
32.00	03200	CORONARY CARE UNIT	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	32.01
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
50.01	03340	GI LAB	50.01
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	MRI CENTER	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03951	EMG	76.00
76.01	03952	CARDIOVASCULAR LAB	76.01
76.02	03953	MERCY EYE CENTER	76.02
76.03	03954	MERCY ENT	76.03
76.04	03955	WOUND CARE CENTER	76.04
76.05	03956	CARDIAC REHAB	76.05
76.06	03957	PRE-BIRTH CENTER	76.06
76.07	03958	SLEEP LAB	76.07
76.08	03640	UROLOGY	76.08
76.09	03959	ADDP OP	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	76.10
76.11	03960	DIABETES TREATMENT	76.11
76.12	03961	MENTAL HEALTH CENTER	76.12
76.13	03650	VEIN CLINIC	76.13
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001	MERCY CLINICS	90.01
90.02	09002	MERCY CLINIC STATE ST	90.02
90.03	09003	MERCY CLINIC POLK ST	90.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			Total	
			26.00	
91.00	09100	EMERGENCY	294,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	93.99
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,507,279	118.00
NONREIMBURSABLE COST CENTERS				
191.00	19100	RESEARCH	1,757	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	95,586	192.00
192.01	19201	DNBAR CLINIC	794	192.01
192.02	19202	PHILLIPS HEALTH	1,013	192.02
192.03	19204	OTHER HOME HEALTH	0	192.03
192.04	19205	VITAS HOSPICE	0	192.04
192.05	19203	DOCTORS OFFICE	2,449	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951	SENIOR FRIENDS	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	194.03
200.00		Cross Foot Adjustments	208,252	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,817,130	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	597,389					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,645,536				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,428	0	78,556,053			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,927	1,974,901	12,014,319	-52,494,062	167,813,132	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	211,956	15,530	1,888,592	0	17,307,433	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,462	0	0	0	1,221,685	8.00
9.00	00900	HOUSEKEEPING	2,248	4,094	1,848,724	0	3,602,687	9.00
10.00	01000	DIETARY	10,504	9,095	0	0	2,372,813	10.00
11.00	01100	CAFETERIA	8,436	7,593	0	0	831,898	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,521	3	1,449,608	0	2,650,923	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,767	43,394	598,036	0	1,595,457	14.00
15.00	01500	PHARMACY	0	19,951	0	0	17,505,496	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,943	2,503	603,913	0	2,354,779	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	8,601	881	685,596	0	7,979,021	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,860	0	1,313,484	0	640,744	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	87,336	314,802	15,607,365	0	22,922,314	30.00
31.00	03100	INTENSIVE CARE UNIT	6,837	526,561	3,359,021	0	5,840,968	31.00
32.00	03200	CORONARY CARE UNIT	7,226	10,295	972,313	0	1,120,114	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	2,166	19,576	1,099,157	0	1,641,802	32.01
40.00	04000	SUBPROVIDER - IPF	13,402	665	1,903,752	0	4,363,387	40.00
41.00	04100	SUBPROVIDER - IRF	5,327	13,491	1,161,238	0	2,272,255	41.00
43.00	04300	NURSERY	1,265	25,885	757,527	-941,347	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,216	89,343	3,310,879	0	5,770,229	50.00
50.01	03340	GI LAB	1,752	7,530	525,423	0	1,002,468	50.01
51.00	05100	RECOVERY ROOM	2,160	0	585,941	0	751,161	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,082	27,730	2,536,169	0	4,089,152	52.00
53.00	05300	ANESTHESIOLOGY	364	1,852	107,438	0	266,581	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,904	226,180	3,162,058	0	4,064,914	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	594	11,109	388,233	0	844,491	55.00
56.00	05600	RADIOISOTOPE	2,167	867	314,192	0	711,604	56.00
57.00	05700	CT SCAN	500	81,549	796,912	0	1,174,658	57.00
58.00	05800	MRI	3,709	507,541	240,288	0	470,013	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,829	170,676	2,190,780	0	2,899,971	59.00
60.00	06000	LABORATORY	15,311	306,269	4,077,937	0	10,100,789	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	887	18,512	1,305,915	0	2,028,511	65.00
66.00	06600	PHYSICAL THERAPY	5,607	44,010	1,032,849	0	1,344,323	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,142	0	524,696	0	711,893	67.00
68.00	06800	SPEECH PATHOLOGY	1,658	0	263,395	0	415,969	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,104	0	52,818	0	77,665	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,203,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,166,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	888	0	0	0	828,042	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	4,876	981	186,320	0	295,959	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	682	19,259	196,535	0	366,489	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	290,348	0	451,450	76.06
76.07	03958	SLEEP LAB	0	0	0	0	514,623	76.07
76.08	03640	UROLOGY	891	1,971	87,497	0	88,412	76.08
76.09	03959	ADDP OP	0	0	109,685	0	124,546	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	1,455	0	0	0	11,933	76.10
76.11	03960	DIABETES TREATMENT	0	0	111,944	0	184,462	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	122,263	0	425,153	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	849	289,594	0	302,061	76.97

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	4,527	84,563	2,433,230	0	8,501,021	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	14,829	27,608	4,393,069	0	8,569,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	593,346	4,617,619	74,899,053	-53,435,409	158,980,852	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	177,366	0	319,838	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,043	16,766	3,197,160	0	8,019,453	192.00
192.01	19201	DNBAR CLINIC	0	0	54,851	0	173,319	192.01
192.02	19202	PHILLIPS HEALTH	0	0	53,763	0	209,717	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	11,151	173,860	0	109,953	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,899,598	564,563	24,224,765		52,494,062	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.201688	0.121528	0.308376		0.312813	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			44,519		671,392	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000567		0.004001	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	340,078				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,462	56,154			8.00
9.00	00900	HOUSEKEEPING	0	2,248	0	328,368		9.00
10.00	01000	DIETARY	0	10,504	0	10,504	50,611	10.00
11.00	01100	CAFETERIA	0	8,436	0	8,436	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,521	0	1,521	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,767	0	7,767	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,943	0	4,943	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	8,601	0	8,601	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,860	0	2,860	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	87,336	37,454	87,336	34,636	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,837	3,944	6,837	4,067	31.00
32.00	03200	CORONARY CARE UNIT	0	7,226	1,444	7,226	1,152	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	2,166	1,840	2,166	0	32.01
40.00	04000	SUBPROVIDER - IPF	0	13,402	7,282	13,402	7,229	40.00
41.00	04100	SUBPROVIDER - IRF	0	5,327	4,190	5,327	3,527	41.00
43.00	04300	NURSERY	0	1,265	0	1,265	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	32,216	0	32,216	0	50.00
50.01	03340	GI LAB	0	1,752	0	1,752	0	50.01
51.00	05100	RECOVERY ROOM	0	2,160	0	2,160	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,082	0	16,082	0	52.00
53.00	05300	ANESTHESIOLOGY	0	364	0	364	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,904	0	22,904	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	594	0	594	0	55.00
56.00	05600	RADIOISOTOPE	0	2,167	0	2,167	0	56.00
57.00	05700	CT SCAN	0	500	0	500	0	57.00
58.00	05800	MRI	0	3,709	0	3,709	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,829	0	17,829	0	59.00
60.00	06000	LABORATORY	0	15,311	0	15,311	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	887	0	887	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,607	0	5,607	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,142	0	2,142	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,658	0	1,658	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,104	0	2,104	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	888	0	888	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	4,876	0	4,876	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	682	0	682	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	891	0	891	0	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	1,455	0	1,455	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	4,527	0	4,527	0	90.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	14,829	0	14,829	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	336,035	56,154	324,325	50,611	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,043	0	4,043	0	192.00
192.01	19201	DNBAR CLINIC	0	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	0	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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	22,721,423	2,236,023	4,879,848	3,972,956	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	66.812387	39.819479	14.860912	78.499852	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,897,382	135,283	55,114	159,239	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	5.579255	2.409143	0.167842	3.146332	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			CAFETERIA (PROD FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURS DIRECT FTE)	CENTRAL SERVICES & SUPPLY (COSTED REQUI)	PHARMACY (COSTED REQUI)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,885,250					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	32,552	0	1,214,584			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,199	0	0	15,612,591		14.00
15.00	01500	PHARMACY	0	0	0	126,290	10,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,484	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	192,870	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	35	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	526,179	0	526,179	1,147,296	0	30.00
31.00	03100	INTENSIVE CARE UNIT	98,076	0	98,076	505,143	0	31.00
32.00	03200	CORONARY CARE UNIT	19,902	0	19,902	87,009	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	24,608	0	24,608	46,599	0	32.01
40.00	04000	SUBPROVIDER - IPF	63,816	0	63,816	12,675	0	40.00
41.00	04100	SUBPROVIDER - IRF	32,682	0	32,682	60,005	0	41.00
43.00	04300	NURSERY	14,640	0	14,640	32,116	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	85,008	0	85,008	1,602,036	0	50.00
50.01	03340	GI LAB	14,957	0	14,957	337,269	0	50.01
51.00	05100	RECOVERY ROOM	11,805	0	11,805	14,167	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	59,887	0	59,887	322,864	0	52.00
53.00	05300	ANESTHESIOLOGY	27,889	0	27,889	186,237	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,907	0	0	165,944	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	10,980	0	0	11,671	0	55.00
56.00	05600	RADIOISOTOPE	6,013	0	0	177,802	0	56.00
57.00	05700	CT SCAN	19,469	0	0	173,542	0	57.00
58.00	05800	MRI	4,806	0	0	8,529	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	49,340	0	49,340	18,443	0	59.00
60.00	06000	LABORATORY	119,150	0	0	2,885,930	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	38,070	0	38,070	0	0	65.00
66.00	06600	PHYSICAL THERAPY	25,186	0	0	6,656	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,812	0	0	7,359	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,783	0	0	1,326	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,972	0	0	1,079	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,521,742	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,352,316	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	23,206	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	6,526	0	0	4,235	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	5,790	0	5,790	5,681	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	9,425	0	0	6,195	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	2,368	0	0	159	0	76.08
76.09	03959	ADDP OP	2,345	0	0	20	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	2,550	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	17,001	0	0	145	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	7,192	0	0	2,627	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		CAFETERIA (PROD FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURS DIRECT FTE)	CENTRAL SERVICES & SUPPLY (COSTED REQUI)	PHARMACY (COSTED REQUI)	
		11.00	12.00	13.00	14.00	15.00	
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 MERCY CLINICS	0	0	0	66,769	0	90.01
90.02	09002 MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	141,935	0	141,935	635,519	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,851,174	0	1,214,584	15,556,636	10,000	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100 RESEARCH	5,678	0	0	84	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	22,746	0	0	45,579	0	192.00
192.01	19201 DNBAR CLINIC	624	0	0	750	0	192.01
192.02	19202 PHILLIPS HEALTH	1,979	0	0	373	0	192.02
192.03	19204 OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205 VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203 DOCTORS OFFICE	3,049	0	0	9,169	0	192.05
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,781,123	0	3,635,145	2,758,370	23,003,755	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.944768	0.000000	2.992914	0.176676	2,300.375500	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	123,694	0	34,780	603,720	77,348	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.065611	0.000000	0.028635	0.038669	7.734800	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	574,905,921					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			9,382	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	77,824,307	0	0	0	5,429	30.00
31.00	03100	INTENSIVE CARE UNIT	15,949,203	0	0	0	364	31.00
32.00	03200	CORONARY CARE UNIT	3,030,259	0	0	0	137	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	7,573,127	0	0	0	268	32.01
40.00	04000	SUBPROVIDER - IPF	12,842,740	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	5,083,325	0	0	0	0	41.00
43.00	04300	NURSERY	4,098,717	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,040,425	0	0	0	800	50.00
50.01	03340	GI LAB	4,983,532	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	2,004,735	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,082,454	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,415,097	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,147,280	0	0	0	1,225	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	6,091,162	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	6,903,420	0	0	0	0	56.00
57.00	05700	CT SCAN	40,808,759	0	0	0	0	57.00
58.00	05800	MRI	8,126,988	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	30,225,908	0	0	0	0	59.00
60.00	06000	LABORATORY	102,927,833	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	14,179,650	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,802,470	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,291,035	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,700,973	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	326,608	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,110,552	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,049,952	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,278,659	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,636,031	0	0	0	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	900,551	0	0	0	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	902,461	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	3,364,048	0	0	0	0	76.06
76.07	03958	SLEEP LAB	1,702,316	0	0	0	0	76.07
76.08	03640	UROLOGY	8,696	0	0	0	0	76.08
76.09	03959	ADDP OP	202,963	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	983,645	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	110,704	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	512,491	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	1,023,267	0	0	0	0	76.97

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	629,224	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	64,030,354	0	0	0	1,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	574,905,921	0	0	0	9,382	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DNBAR CLINIC	0	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	0	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,533,343	0	0	0	11,359,651	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006146	0.000000	0.000000	0.000000	1,210.792049	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	81,672	0	0	0	165,048	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000142	0.000000	0.000000	0.000000	17.591985	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	9,382		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,429	0	30.00
31.00	03100	INTENSIVE CARE UNIT	364	0	31.00
32.00	03200	CORONARY CARE UNIT	137	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	268	0	32.01
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	800	0	50.00
50.01	03340	GI LAB	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,225	0	54.00
54.01	05401	MRI CENTER	0	0	54.01
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	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03951	EMG	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	0	76.02
76.03	03954	MERCY ENT	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	76.06
76.07	03958	SLEEP LAB	0	0	76.07
76.08	03640	UROLOGY	0	0	76.08
76.09	03959	ADDP OP	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	76.97

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet B-1
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
			22.00			
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	MERCY CLINICS	0	0		90.01
90.02	09002	MERCY CLINIC STATE ST	0	0		90.02
90.03	09003	MERCY CLINIC POLK ST	0	0		90.03
91.00	09100	EMERGENCY	1,159	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,382	100		118.00
NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	DNBAR CLINIC	0	0		192.01
192.02	19202	PHILLIPS HEALTH	0	0		192.02
192.03	19204	OTHER HOME HEALTH	0	0		192.03
192.04	19205	VITAS HOSPICE	0	0		192.04
192.05	19203	DOCTORS OFFICE	0	0		192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	SENIOR FRIENDS	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.03
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,074,768	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	114.556385	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,204	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.604988	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,188,918	44,188,918	0	44,188,918 30.00
31.00	03100	INTENSIVE CARE UNIT	9,276,269	9,276,269	0	9,276,269 31.00
32.00	03200	CORONARY CARE UNIT	2,320,966	2,320,966	0	2,320,966 32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	2,557,228	2,557,228	0	2,557,228 32.01
40.00	04000	SUBPROVIDER - IPF	8,012,794	8,012,794	0	8,012,794 40.00
41.00	04100	SUBPROVIDER - IRF	4,032,367	4,032,367	0	4,032,367 41.00
43.00	04300	NURSERY	1,133,176	1,133,176	0	1,133,176 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,928,925	10,928,925	0	10,928,925 50.00
50.01	03340	GI LAB	1,608,256	1,608,256	0	1,608,256 50.01
51.00	05100	RECOVERY ROOM	1,223,857	1,223,857	0	1,223,857 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,042,733	7,042,733	0	7,042,733 52.00
53.00	05300	ANESTHESIOLOGY	549,557	549,557	0	549,557 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,579,946	7,579,946	0	7,579,946 54.00
54.01	05401	MRI CENTER	0	0	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,207,045	1,207,045	0	1,207,045 55.00
56.00	05600	RADIOISOTOPE	1,190,711	1,190,711	0	1,190,711 56.00
57.00	05700	CT SCAN	1,882,808	1,882,808	0	1,882,808 57.00
58.00	05800	MRI	975,961	975,961	0	975,961 58.00
59.00	05900	CARDIAC CATHETERIZATION	5,646,584	5,646,584	114,812	5,761,396 59.00
60.00	06000	LABORATORY	15,765,960	15,765,960	0	15,765,960 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	2,972,556	2,972,556	0	2,972,556 65.00
66.00	06600	PHYSICAL THERAPY	2,271,128	2,271,128	0	2,271,128 66.00
67.00	06700	OCCUPATIONAL THERAPY	1,138,901	1,138,901	0	1,138,901 67.00
68.00	06800	SPEECH PATHOLOGY	698,600	698,600	0	698,600 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	277,861	277,861	0	277,861 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,375,229	3,375,229	0	3,375,229 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,968,770	4,968,770	0	4,968,770 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,368,082	23,368,082	0	23,368,082 73.00
74.00	07400	RENAL DIALYSIS	1,173,744	1,173,744	0	1,173,744 74.00
76.00	03951	EMG	0	0	0	0 76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0 76.01
76.02	03953	MERCY EYE CENTER	799,227	799,227	0	799,227 76.02
76.03	03954	MERCY ENT	0	0	0	0 76.03
76.04	03955	WOUND CARE CENTER	566,183	566,183	0	566,183 76.04
76.05	03956	CARDIAC REHAB	0	0	0	0 76.05
76.06	03957	PRE-BIRTH CENTER	623,343	623,343	0	623,343 76.06
76.07	03958	SLEEP LAB	686,066	686,066	0	686,066 76.07
76.08	03640	UROLOGY	191,157	191,157	0	191,157 76.08
76.09	03959	ADDP OP	166,972	166,972	0	166,972 76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	140,546	140,546	0	140,546 76.10
76.11	03960	DIABETES TREATMENT	245,253	245,253	0	245,253 76.11
76.12	03961	MENTAL HEALTH CENTER	577,384	577,384	0	577,384 76.12
76.13	03650	VEIN CLINIC	0	0	0	0 76.13
76.97	07697	CARDIAC REHABILITATION	410,098	410,098	57,838	467,936 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	MERCY CLINICS	11,545,649	11,545,649	0	11,545,649 90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0 90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0 90.03
91.00	09100	EMERGENCY	13,525,894	13,525,894	0	13,525,894 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,119,288	8,119,288	0	8,119,288 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0 99.40
200.00		Subtotal (see instructions)	204,965,992	204,965,992	172,650	205,138,642 200.00
201.00		Less Observation Beds	8,119,288	8,119,288	0	8,119,288 201.00
202.00		Total (see instructions)	196,846,704	196,846,704	172,650	197,019,354 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 1:27 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	68,623,745		68,623,745		30.00
31.00	03100	INTENSIVE CARE UNIT	15,949,203		15,949,203		31.00
32.00	03200	CORONARY CARE UNIT	3,030,259		3,030,259		32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	7,573,127		7,573,127		32.01
40.00	04000	SUBPROVIDER - IPF	12,842,740		12,842,740		40.00
41.00	04100	SUBPROVIDER - IRF	5,083,325		5,083,325		41.00
43.00	04300	NURSERY	4,098,717		4,098,717		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,059,376	8,981,049	17,040,425	0.641353	50.00
50.01	03340	GI LAB	1,371,748	3,611,784	4,983,532	0.322714	50.01
51.00	05100	RECOVERY ROOM	921,204	1,083,531	2,004,735	0.610483	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,352,294	730,160	11,082,454	0.635485	52.00
53.00	05300	ANESTHESIOLOGY	1,672,488	2,742,609	4,415,097	0.124472	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,434,132	31,713,148	43,147,280	0.175676	54.00
54.01	05401	MRI CENTER	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	343,238	5,747,924	6,091,162	0.198163	55.00
56.00	05600	RADIOISOTOPE	1,708,019	5,195,401	6,903,420	0.172481	56.00
57.00	05700	CT SCAN	14,283,669	26,525,090	40,808,759	0.046137	57.00
58.00	05800	MRI	2,533,392	5,593,596	8,126,988	0.120089	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,773,774	12,452,134	30,225,908	0.186813	59.00
60.00	06000	LABORATORY	51,892,832	51,035,001	102,927,833	0.153175	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	13,052,534	1,127,116	14,179,650	0.209635	65.00
66.00	06600	PHYSICAL THERAPY	2,391,208	1,411,262	3,802,470	0.597277	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,717,831	573,204	2,291,035	0.497112	67.00
68.00	06800	SPEECH PATHOLOGY	1,214,083	486,890	1,700,973	0.410706	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	216,914	109,694	326,608	0.850748	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,576,046	1,534,506	6,110,552	0.552361	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,127,869	2,922,083	7,049,952	0.704795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,786,315	40,492,344	59,278,659	0.394207	73.00
74.00	07400	RENAL DIALYSIS	1,519,442	116,589	1,636,031	0.717434	74.00
76.00	03951	EMG	0	0	0	0.000000	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0.000000	76.01
76.02	03953	MERCY EYE CENTER	0	900,551	900,551	0.887487	76.02
76.03	03954	MERCY ENT	0	0	0	0.000000	76.03
76.04	03955	WOUND CARE CENTER	5,104	897,357	902,461	0.627377	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0.000000	76.05
76.06	03957	PRE-BIRTH CENTER	139,418	3,224,630	3,364,048	0.185296	76.06
76.07	03958	SLEEP LAB	0	1,702,316	1,702,316	0.403019	76.07
76.08	03640	UROLOGY	0	8,696	8,696	21.982176	76.08
76.09	03959	ADDP OP	198	202,765	202,963	0.822672	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	4,484	979,161	983,645	0.142883	76.10
76.11	03960	DIABETES TREATMENT	180	110,524	110,704	2.215394	76.11
76.12	03961	MENTAL HEALTH CENTER	0	512,491	512,491	1.126623	76.12
76.13	03650	VEIN CLINIC	0	0	0	0.000000	76.13
76.97	07697	CARDIAC REHABILITATION	1,797	1,021,470	1,023,267	0.400773	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	30,048	599,176	629,224	18.349028	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0.000000	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	17,221,576	46,808,778	64,030,354	0.211242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	82,014	9,118,548	9,200,562	0.882477	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	304,634,343	270,271,578	574,905,921		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	304,634,343	270,271,578	574,905,921		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER			32.01
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.641353		50.00
50.01	03340	GI LAB	0.322714		50.01
51.00	05100	RECOVERY ROOM	0.610483		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.635485		52.00
53.00	05300	ANESTHESIOLOGY	0.124472		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175676		54.00
54.01	05401	MRI CENTER	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198163		55.00
56.00	05600	RADIOISOTOPE	0.172481		56.00
57.00	05700	CT SCAN	0.046137		57.00
58.00	05800	MRI	0.120089		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.190611		59.00
60.00	06000	LABORATORY	0.153175		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.209635		65.00
66.00	06600	PHYSICAL THERAPY	0.597277		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.497112		67.00
68.00	06800	SPEECH PATHOLOGY	0.410706		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.850748		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.552361		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.704795		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.394207		73.00
74.00	07400	RENAL DIALYSIS	0.717434		74.00
76.00	03951	EMG	0.000000		76.00
76.01	03952	CARDIOVASCULAR LAB	0.000000		76.01
76.02	03953	MERCY EYE CENTER	0.887487		76.02
76.03	03954	MERCY ENT	0.000000		76.03
76.04	03955	WOUND CARE CENTER	0.627377		76.04
76.05	03956	CARDIAC REHAB	0.000000		76.05
76.06	03957	PRE-BIRTH CENTER	0.185296		76.06
76.07	03958	SLEEP LAB	0.403019		76.07
76.08	03640	UROLOGY	21.982176		76.08
76.09	03959	ADDP OP	0.822672		76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0.142883		76.10
76.11	03960	DIABETES TREATMENT	2.215394		76.11
76.12	03961	MENTAL HEALTH CENTER	1.126623		76.12
76.13	03650	VEIN CLINIC	0.000000		76.13
76.97	07697	CARDIAC REHABILITATION	0.457296		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	MERCY CLINICS	18.349028		90.01
90.02	09002	MERCY CLINIC STATE ST	0.000000		90.02
90.03	09003	MERCY CLINIC POLK ST	0.000000		90.03
91.00	09100	EMERGENCY	0.211242		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.882477		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 1/28/2021 1:27 pm
			Title XIX	Hospital	Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	51,384,234		51,384,234	0	0 30.00
31.00 03100 INTENSIVE CARE UNIT	9,758,696		9,758,696	0	0 31.00
32.00 03200 CORONARY CARE UNIT	2,502,539		2,502,539	0	0 32.00
32.01 02060 NURSERY INTENSIVE CARE CENTER	2,912,421		2,912,421	0	0 32.01
40.00 04000 SUBPROVIDER - IPF	8,012,794		8,012,794	0	0 40.00
41.00 04100 SUBPROVIDER - IRF	4,032,367		4,032,367	0	0 41.00
43.00 04300 NURSERY	1,133,176		1,133,176	0	0 43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	11,989,204		11,989,204	0	0 50.00
50.01 03340 GI LAB	1,608,256		1,608,256	0	0 50.01
51.00 05100 RECOVERY ROOM	1,223,857		1,223,857	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7,042,733		7,042,733	0	0 52.00
53.00 05300 ANESTHESIOLOGY	549,557		549,557	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,203,498		9,203,498	0	0 54.00
54.01 05401 MRI CENTER	0		0	0	0 54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	1,207,045		1,207,045	0	0 55.00
56.00 05600 RADIOISOTOPE	1,190,711		1,190,711	0	0 56.00
57.00 05700 CT SCAN	1,882,808		1,882,808	0	0 57.00
58.00 05800 MRI	975,961		975,961	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	5,646,584		5,646,584	0	0 59.00
60.00 06000 LABORATORY	15,765,960		15,765,960	0	0 60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
65.00 06500 RESPIRATORY THERAPY	2,972,556	0	2,972,556	0	0 65.00
66.00 06600 PHYSICAL THERAPY	2,271,128	0	2,271,128	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	1,138,901	0	1,138,901	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	698,600	0	698,600	0	0 68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	277,861		277,861	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,375,229		3,375,229	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4,968,770		4,968,770	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	23,368,082		23,368,082	0	0 73.00
74.00 07400 RENAL DIALYSIS	1,173,744		1,173,744	0	0 74.00
76.00 03951 EMG	0		0	0	0 76.00
76.01 03952 CARDIOVASCULAR LAB	0		0	0	0 76.01
76.02 03953 MERCY EYE CENTER	799,227		799,227	0	0 76.02
76.03 03954 MERCY ENT	0		0	0	0 76.03
76.04 03955 WOUND CARE CENTER	566,183		566,183	0	0 76.04
76.05 03956 CARDIAC REHAB	0		0	0	0 76.05
76.06 03957 PRE-BIRTH CENTER	623,343		623,343	0	0 76.06
76.07 03958 SLEEP LAB	686,066		686,066	0	0 76.07
76.08 03640 UROLOGY	191,157		191,157	0	0 76.08
76.09 03959 ADPP OP	166,972		166,972	0	0 76.09
76.10 03550 PSYCH PARTIAL HOSPITAL	140,546		140,546	0	0 76.10
76.11 03960 DIABETES TREATMENT	245,253		245,253	0	0 76.11
76.12 03961 MENTAL HEALTH CENTER	577,384		577,384	0	0 76.12
76.13 03650 VEIN CLINIC	0		0	0	0 76.13
76.97 07697 CARDIAC REHABILITATION	410,098		410,098	0	0 76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98
76.99 07699 LITHOTRIPSY	0		0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 09001 MERCY CLINICS	11,545,649		11,545,649	0	0 90.01
90.02 09002 MERCY CLINIC STATE ST	0		0	0	0 90.02
90.03 09003 MERCY CLINIC POLK ST	0		0	0	0 90.03
91.00 09100 EMERGENCY	15,061,973		15,061,973	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	9,441,328		9,441,328	0	0 92.00
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS					
99.10 09910 CORF	0		0		0 99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0		0		0 99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0		0 99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0 99.40
200.00 Subtotal (see instructions)	218,722,451	0	218,722,451	0	0 200.00
201.00 Less Observation Beds	9,441,328		9,441,328		0 201.00
202.00 Total (see instructions)	209,281,123	0	209,281,123	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
32.00	03200	CORONARY CARE UNIT	0		0			32.00	
32.01	02060	NURSERY INTENSIVE CARE CENTER	0		0			32.01	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
41.00	04100	SUBPROVIDER - IRF	0		0			41.00	
43.00	04300	NURSERY	0		0			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
50.01	03340	GI LAB	0	0	0	0.000000	0.000000	50.01	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
54.01	05401	MRI CENTER	0	0	0	0.000000	0.000000	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00	
76.00	03951	EMG	0	0	0	0.000000	0.000000	76.00	
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0.000000	0.000000	76.01	
76.02	03953	MERCY EYE CENTER	0	0	0	0.000000	0.000000	76.02	
76.03	03954	MERCY ENT	0	0	0	0.000000	0.000000	76.03	
76.04	03955	WOUND CARE CENTER	0	0	0	0.000000	0.000000	76.04	
76.05	03956	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.05	
76.06	03957	PRE-BIRTH CENTER	0	0	0	0.000000	0.000000	76.06	
76.07	03958	SLEEP LAB	0	0	0	0.000000	0.000000	76.07	
76.08	03640	UROLOGY	0	0	0	0.000000	0.000000	76.08	
76.09	03959	ADDP OP	0	0	0	0.000000	0.000000	76.09	
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0.000000	0.000000	76.10	
76.11	03960	DIABETES TREATMENT	0	0	0	0.000000	0.000000	76.11	
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0.000000	0.000000	76.12	
76.13	03650	VEIN CLINIC	0	0	0	0.000000	0.000000	76.13	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0.000000	0.000000	90.01	
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0.000000	0.000000	90.02	
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0.000000	0.000000	90.03	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 1:27 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
32.00	03200	CORONARY CARE UNIT				32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER				32.01
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
50.01	03340	GI LAB	0.000000			50.01
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	MRI CENTER	0.000000			54.01
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	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03951	EMG	0.000000			76.00
76.01	03952	CARDIOVASCULAR LAB	0.000000			76.01
76.02	03953	MERCY EYE CENTER	0.000000			76.02
76.03	03954	MERCY ENT	0.000000			76.03
76.04	03955	WOUND CARE CENTER	0.000000			76.04
76.05	03956	CARDIAC REHAB	0.000000			76.05
76.06	03957	PRE-BIRTH CENTER	0.000000			76.06
76.07	03958	SLEEP LAB	0.000000			76.07
76.08	03640	UROLOGY	0.000000			76.08
76.09	03959	ADDP OP	0.000000			76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0.000000			76.10
76.11	03960	DIABETES TREATMENT	0.000000			76.11
76.12	03961	MENTAL HEALTH CENTER	0.000000			76.12
76.13	03650	VEIN CLINIC	0.000000			76.13
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	MERCY CLINICS	0.000000			90.01
90.02	09002	MERCY CLINIC STATE ST	0.000000			90.02
90.03	09003	MERCY CLINIC POLK ST	0.000000			90.03
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
1/28/2021 1:27 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	1,687,059	0	1,687,059	36,938	45.67	30.00	
31.00	INTENSIVE CARE UNIT	243,273		243,273	4,809	50.59	31.00	
32.00	CORONARY CARE UNIT	120,539		120,539	1,235	97.60	32.00	
32.01	NURSERY INTENSIVE CARE CENTER	49,415		49,415	1,041	47.47	32.01	
40.00	SUBPROVIDER - IPF	254,234	0	254,234	6,930	36.69	40.00	
41.00	SUBPROVIDER - IRF	115,723	0	115,723	2,725	42.47	41.00	
43.00	NURSERY	24,425		24,425	3,234	7.55	43.00	
200.00	Total (lines 30 through 199)	2,494,668		2,494,668	56,912		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,133	417,104					30.00
31.00	INTENSIVE CARE UNIT	1,525	77,150					31.00
32.00	CORONARY CARE UNIT	295	28,792					32.00
32.01	NURSERY INTENSIVE CARE CENTER	0	0					32.01
40.00	SUBPROVIDER - IPF	928	34,048					40.00
41.00	SUBPROVIDER - IRF	1,427	60,605					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	13,308	617,699					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,644,338	17,040,425	0.096496	1,744,122	168,301	50.00
50.01	03340	GI LAB	194,051	4,983,532	0.038938	481,236	18,738	50.01
51.00	05100	RECOVERY ROOM	41,083	2,004,735	0.020493	251,944	5,163	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	274,542	11,082,454	0.024773	18,248	452	52.00
53.00	05300	ANESTHESIOLOGY	16,888	4,415,097	0.003825	357,333	1,367	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	383,010	43,147,280	0.008877	3,841,442	34,100	54.00
54.01	05401	MRI CENTER	0	0	0.000000	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	15,271	6,091,162	0.002507	148,553	372	55.00
56.00	05600	RADIOISOTOPE	41,607	6,903,420	0.006027	437,236	2,635	56.00
57.00	05700	CT SCAN	35,820	40,808,759	0.000878	4,861,390	4,268	57.00
58.00	05800	MRI	1,041,422	8,126,988	0.128144	849,993	108,922	58.00
59.00	05900	CARDIAC CATHETERIZATION	291,935	30,225,908	0.009658	5,472,634	52,855	59.00
60.00	06000	LABORATORY	427,578	102,927,833	0.004154	14,903,793	61,910	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	73,920	14,179,650	0.005213	4,401,952	22,947	65.00
66.00	06600	PHYSICAL THERAPY	91,973	3,802,470	0.024188	521,613	12,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,607	2,291,035	0.015105	227,394	3,435	67.00
68.00	06800	SPEECH PATHOLOGY	25,677	1,700,973	0.015095	279,578	4,220	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,906	326,608	0.091565	67,820	6,210	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,195	6,110,552	0.017543	1,525,111	26,755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,964	7,049,952	0.025811	1,049,961	27,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,766	59,278,659	0.001447	5,307,298	7,680	73.00
74.00	07400	RENAL DIALYSIS	16,828	1,636,031	0.010286	616,543	6,342	74.00
76.00	03951	EMG	0	0	0.000000	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0.000000	0	0	76.01
76.02	03953	MERCY EYE CENTER	70,142	900,551	0.077888	0	0	76.02
76.03	03954	MERCY ENT	0	0	0.000000	0	0	76.03
76.04	03955	WOUND CARE CENTER	14,809	902,461	0.016410	1,854	30	76.04
76.05	03956	CARDIAC REHAB	0	0	0.000000	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	3,307	3,364,048	0.000983	0	0	76.06
76.07	03958	SLEEP LAB	2,301	1,702,316	0.001352	0	0	76.07
76.08	03640	UROLOGY	13,235	8,696	1.521964	0	0	76.08
76.09	03959	ADDP OP	744	202,963	0.003666	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	20,483	983,645	0.020824	0	0	76.10
76.11	03960	DIABETES TREATMENT	984	110,704	0.008889	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	2,964	512,491	0.005784	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0.000000	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	2,195	1,023,267	0.002145	170	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	532,044	629,224	0.845556	730	617	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0.000000	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	294,022	64,030,354	0.004592	4,571,820	20,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,978	9,200,562	0.033691	30,638	1,032	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	6,322,589	457,704,805		51,970,406	599,063	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 1/28/2021 1:27 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	0	32.00	
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	0	0	0	0	32.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	36,938	0.00	9,133	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	4,809	0.00	1,525	31.00		
32.00	03200	CORONARY CARE UNIT	0	0	1,235	0.00	295	32.00		
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	1,041	0.00	0	32.01		
40.00	04000	SUBPROVIDER - IPF	0	0	6,930	0.00	928	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	2,725	0.00	1,427	41.00		
43.00	04300	NURSERY	0	0	3,234	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	56,912		13,308	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
32.00	03200	CORONARY CARE UNIT	0						32.00	
32.01	02060	NURSERY INTENSIVE CARE CENTER	0						32.01	
40.00	04000	SUBPROVIDER - IPF	0						40.00	
41.00	04100	SUBPROVIDER - IRF	0						41.00	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 1:27 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	03340	GI LAB	0	0	0	0	0	50.01
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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	0	0	0	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	0	0	0	0	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			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	17,040,425	0.000000
50.01	03340	GI LAB	0	0	0	4,983,532	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	2,004,735	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	11,082,454	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	4,415,097	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,147,280	0.000000
54.01	05401	MRI CENTER	0	0	0	0	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,091,162	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	6,903,420	0.000000
57.00	05700	CT SCAN	0	0	0	40,808,759	0.000000
58.00	05800	MRI	0	0	0	8,126,988	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	30,225,908	0.000000
60.00	06000	LABORATORY	0	0	0	102,927,833	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,179,650	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	3,802,470	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,291,035	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,700,973	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	326,608	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,110,552	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,049,952	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,278,659	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	1,636,031	0.000000
76.00	03951	EMG	0	0	0	0	0.000000
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0.000000
76.02	03953	MERCY EYE CENTER	0	0	0	900,551	0.000000
76.03	03954	MERCY ENT	0	0	0	0	0.000000
76.04	03955	WOUND CARE CENTER	0	0	0	902,461	0.000000
76.05	03956	CARDIAC REHAB	0	0	0	0	0.000000
76.06	03957	PRE-BIRTH CENTER	0	0	0	3,364,048	0.000000
76.07	03958	SLEEP LAB	0	0	0	1,702,316	0.000000
76.08	03640	UROLOGY	0	0	0	8,696	0.000000
76.09	03959	ADDP OP	0	0	0	202,963	0.000000
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	983,645	0.000000
76.11	03960	DIABETES TREATMENT	0	0	0	110,704	0.000000
76.12	03961	MENTAL HEALTH CENTER	0	0	0	512,491	0.000000
76.13	03650	VEIN CLINIC	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,023,267	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	0	0	0	629,224	0.000000
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0.000000
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	64,030,354	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,200,562	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	0	0	457,704,805	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
Provider CCN: 14-0158
Period: From 07/01/2019 To 06/30/2020
Worksheet D Part IV Date/Time Prepared: 1/28/2021 1:27 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	1,744,122	0	1,880,398	0	50.00	
50.01	03340 GI LAB	0.000000	481,236	0	759,192	0	50.01	
51.00	05100 RECOVERY ROOM	0.000000	251,944	0	146,492	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	18,248	0	2,660	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	357,333	0	490,308	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,841,442	0	3,640,038	0	54.00	
54.01	05401 MRI CENTER	0.000000	0	0	0	0	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	148,553	0	1,759,940	0	55.00	
56.00	05600 RADIOISOTOPE	0.000000	437,236	0	1,606,113	0	56.00	
57.00	05700 CT SCAN	0.000000	4,861,390	0	5,877,932	0	57.00	
58.00	05800 MRI	0.000000	849,993	0	1,245,947	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	5,472,634	0	3,676,269	0	59.00	
60.00	06000 LABORATORY	0.000000	14,903,793	0	5,379,405	0	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500 RESPIRATORY THERAPY	0.000000	4,401,952	0	266,255	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	521,613	0	3,780	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	227,394	0	1,706	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	279,578	0	53,254	0	68.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	67,820	0	36,590	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,525,111	0	428,621	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,049,961	0	749,753	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	5,307,298	0	12,514,357	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	616,543	0	75,139	0	74.00	
76.00	03951 EMG	0.000000	0	0	0	0	76.00	
76.01	03952 CARDIOVASCULAR LAB	0.000000	0	0	0	0	76.01	
76.02	03953 MERCY EYE CENTER	0.000000	0	0	336,515	0	76.02	
76.03	03954 MERCY ENT	0.000000	0	0	0	0	76.03	
76.04	03955 WOUND CARE CENTER	0.000000	1,854	0	405,974	0	76.04	
76.05	03956 CARDIAC REHAB	0.000000	0	0	0	0	76.05	
76.06	03957 PRE-BIRTH CENTER	0.000000	0	0	463	0	76.06	
76.07	03958 SLEEP LAB	0.000000	0	0	268,105	0	76.07	
76.08	03640 UROLOGY	0.000000	0	0	0	0	76.08	
76.09	03959 ADDP OP	0.000000	0	0	0	0	76.09	
76.10	03550 PSYCH PARTIAL HOSPITAL	0.000000	0	0	127,215	0	76.10	
76.11	03960 DIABETES TREATMENT	0.000000	0	0	10,829	0	76.11	
76.12	03961 MENTAL HEALTH CENTER	0.000000	0	0	229,893	0	76.12	
76.13	03650 VEIN CLINIC	0.000000	0	0	0	0	76.13	
76.97	07697 CARDIAC REHABILITATION	0.000000	170	0	219,568	0	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 MERCY CLINICS	0.000000	730	0	47,496	0	90.01	
90.02	09002 MERCY CLINIC STATE ST	0.000000	0	0	0	0	90.02	
90.03	09003 MERCY CLINIC POLK ST	0.000000	0	0	0	0	90.03	
91.00	09100 EMERGENCY	0.000000	4,571,820	0	5,273,361	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	30,638	0	1,762,725	0	92.00	
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00	Total (lines 50 through 199)		51,970,406	0	49,276,293	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 1/28/2021 1:27 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	0.641353	1,880,398	0	0	1,205,999	50.00
50.01	03340	GI LAB	0.322714	759,192	0	0	245,002	50.01
51.00	05100	RECOVERY ROOM	0.610483	146,492	0	0	89,431	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.635485	2,660	0	0	1,690	52.00
53.00	05300	ANESTHESIOLOGY	0.124472	490,308	0	0	61,030	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175676	3,640,038	0	0	639,467	54.00
54.01	05401	MRI CENTER	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198163	1,759,940	0	0	348,755	55.00
56.00	05600	RADIOISOTOPE	0.172481	1,606,113	0	0	277,024	56.00
57.00	05700	CT SCAN	0.046137	5,877,932	0	0	271,190	57.00
58.00	05800	MRI	0.120089	1,245,947	0	0	149,625	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.186813	3,676,269	0	0	686,775	59.00
60.00	06000	LABORATORY	0.153175	5,379,405	0	0	823,990	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.209635	266,255	0	0	55,816	65.00
66.00	06600	PHYSICAL THERAPY	0.597277	3,780	0	0	2,258	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.497112	1,706	0	0	848	67.00
68.00	06800	SPEECH PATHOLOGY	0.410706	53,254	0	0	21,872	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.850748	36,590	0	0	31,129	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.552361	428,621	0	0	236,754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.704795	749,753	0	0	528,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.394207	12,514,357	0	17,643	4,933,247	73.00
74.00	07400	RENAL DIALYSIS	0.717434	75,139	0	0	53,907	74.00
76.00	03951	EMG	0.000000	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0.000000	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0.887487	336,515	0	0	298,653	76.02
76.03	03954	MERCY ENT	0.000000	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0.627377	405,974	0	0	254,699	76.04
76.05	03956	CARDIAC REHAB	0.000000	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0.185296	463	0	0	86	76.06
76.07	03958	SLEEP LAB	0.403019	268,105	0	0	108,051	76.07
76.08	03640	UROLOGY	21.982176	0	0	0	0	76.08
76.09	03959	ADDP OP	0.822672	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0.142883	127,215	0	0	18,177	76.10
76.11	03960	DIABETES TREATMENT	2.215394	10,829	0	0	23,991	76.11
76.12	03961	MENTAL HEALTH CENTER	1.126623	229,893	0	0	259,003	76.12
76.13	03650	VEIN CLINIC	0.000000	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0.400773	219,568	0	0	87,997	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	18.349028	47,496	0	0	871,505	90.01
90.02	09002	MERCY CLINIC STATE ST	0.000000	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.211242	5,273,361	0	0	1,113,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.882477	1,762,725	0	0	1,555,564	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		49,276,293	0	17,643	15,255,912	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		49,276,293	0	17,643	15,255,912	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 1/28/2021 1:27 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					
50.01	03340	GI LAB	0	0					
51.00	05100	RECOVERY ROOM	0	0					
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
54.01	05401	MRI CENTER	0	0					
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					
56.00	05600	RADIOISOTOPE	0	0					
57.00	05700	CT SCAN	0	0					
58.00	05800	MRI	0	0					
59.00	05900	CARDIAC CATHETERIZATION	0	0					
60.00	06000	LABORATORY	0	0					
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
67.00	06700	OCCUPATIONAL THERAPY	0	0					
68.00	06800	SPEECH PATHOLOGY	0	0					
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,955					
74.00	07400	RENAL DIALYSIS	0	0					
76.00	03951	EMG	0	0					
76.01	03952	CARDIOVASCULAR LAB	0	0					
76.02	03953	MERCY EYE CENTER	0	0					
76.03	03954	MERCY ENT	0	0					
76.04	03955	WOUND CARE CENTER	0	0					
76.05	03956	CARDIAC REHAB	0	0					
76.06	03957	PRE-BIRTH CENTER	0	0					
76.07	03958	SLEEP LAB	0	0					
76.08	03640	UROLOGY	0	0					
76.09	03959	ADDP OP	0	0					
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0					
76.11	03960	DIABETES TREATMENT	0	0					
76.12	03961	MENTAL HEALTH CENTER	0	0					
76.13	03650	VEIN CLINIC	0	0					
76.97	07697	CARDIAC REHABILITATION	0	0					
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					
76.99	07699	LITHOTRIPSY	0	0					
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS	0	0					
90.02	09002	MERCY CLINIC STATE ST	0	0					
90.03	09003	MERCY CLINIC POLK ST	0	0					
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0					
200.00		Subtotal (see instructions)	0	6,955					
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						
202.00		Net Charges (line 200 - line 201)	0	6,955					

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 1/28/2021 1:27 pm
				Component CCN: 14-S158		
				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	1,644,338	17,040,425	0.096496	0
50.01	03340	GI LAB	194,051	4,983,532	0.038938	0
51.00	05100	RECOVERY ROOM	41,083	2,004,735	0.020493	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	274,542	11,082,454	0.024773	0
53.00	05300	ANESTHESIOLOGY	16,888	4,415,097	0.003825	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	383,010	43,147,280	0.008877	11,032
54.01	05401	MRI CENTER	0	0	0.000000	0
55.00	05500	RADIOLOGY-THERAPEUTIC	15,271	6,091,162	0.002507	0
56.00	05600	RADIOISOTOPE	41,607	6,903,420	0.006027	0
57.00	05700	CT SCAN	35,820	40,808,759	0.000878	9,286
58.00	05800	MRI	1,041,422	8,126,988	0.128144	0
59.00	05900	CARDIAC CATHETERIZATION	291,935	30,225,908	0.009658	17,708
60.00	06000	LABORATORY	427,578	102,927,833	0.004154	123,121
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0
65.00	06500	RESPIRATORY THERAPY	73,920	14,179,650	0.005213	466
66.00	06600	PHYSICAL THERAPY	91,973	3,802,470	0.024188	1,092
67.00	06700	OCCUPATIONAL THERAPY	34,607	2,291,035	0.015105	0
68.00	06800	SPEECH PATHOLOGY	25,677	1,700,973	0.015095	995
70.00	07000	ELECTROENCEPHALOGRAPHY	29,906	326,608	0.091565	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,195	6,110,552	0.017543	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,964	7,049,952	0.025811	0
73.00	07300	DRUGS CHARGED TO PATIENTS	85,766	59,278,659	0.001447	61,265
74.00	07400	RENAL DIALYSIS	16,828	1,636,031	0.010286	0
76.00	03951	EMG	0	0	0.000000	0
76.01	03952	CARDIOVASCULAR LAB	0	0	0.000000	0
76.02	03953	MERCY EYE CENTER	70,142	900,551	0.077888	0
76.03	03954	MERCY ENT	0	0	0.000000	0
76.04	03955	WOUND CARE CENTER	14,809	902,461	0.016410	0
76.05	03956	CARDIAC REHAB	0	0	0.000000	0
76.06	03957	PRE-BIRTH CENTER	3,307	3,364,048	0.000983	0
76.07	03958	SLEEP LAB	2,301	1,702,316	0.001352	0
76.08	03640	UROLOGY	13,235	8,696	1.521964	0
76.09	03959	ADDP OP	744	202,963	0.003666	0
76.10	03550	PSYCH PARTIAL HOSPITAL	20,483	983,645	0.020824	0
76.11	03960	DIABETES TREATMENT	984	110,704	0.008889	0
76.12	03961	MENTAL HEALTH CENTER	2,964	512,491	0.005784	0
76.13	03650	VEIN CLINIC	0	0	0.000000	0
76.97	07697	CARDIAC REHABILITATION	2,195	1,023,267	0.002145	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0
76.99	07699	LITHOTRIPSY	0	0	0.000000	0
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	MERCY CLINICS	532,044	629,224	0.845556	0
90.02	09002	MERCY CLINIC STATE ST	0	0	0.000000	0
90.03	09003	MERCY CLINIC POLK ST	0	0	0.000000	0
91.00	09100	EMERGENCY	294,022	64,030,354	0.004592	175,021
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,200,562	0.000000	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0
200.00		Total (lines 50 through 199)	6,012,611	457,704,805		399,986

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

 Provider CCN: 14-0158
Component CCN: 14-S158

 Period:
From 07/01/2019
To 06/30/2020

 Worksheet D
Part IV
Date/Time Prepared:
1/28/2021 1:27 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
50.01	03340	GI LAB	0	0	0	0	0	50.01
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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	0	0	0	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	0	0	0	0	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-S158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 1:27 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
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	17,040,425	0.000000	50.00	
50.01	03340	GI LAB	0	0	0	4,983,532	0.000000	50.01	
51.00	05100	RECOVERY ROOM	0	0	0	2,004,735	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	11,082,454	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	4,415,097	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,147,280	0.000000	54.00	
54.01	05401	MRI CENTER	0	0	0	0	0.000000	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,091,162	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	6,903,420	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	40,808,759	0.000000	57.00	
58.00	05800	MRI	0	0	0	8,126,988	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	30,225,908	0.000000	59.00	
60.00	06000	LABORATORY	0	0	0	102,927,833	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,179,650	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	3,802,470	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,291,035	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,700,973	0.000000	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	326,608	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,110,552	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,049,952	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,278,659	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	1,636,031	0.000000	74.00	
76.00	03951	EMG	0	0	0	0	0.000000	76.00	
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0.000000	76.01	
76.02	03953	MERCY EYE CENTER	0	0	0	900,551	0.000000	76.02	
76.03	03954	MERCY ENT	0	0	0	0	0.000000	76.03	
76.04	03955	WOUND CARE CENTER	0	0	0	902,461	0.000000	76.04	
76.05	03956	CARDIAC REHAB	0	0	0	0	0.000000	76.05	
76.06	03957	PRE-BIRTH CENTER	0	0	0	3,364,048	0.000000	76.06	
76.07	03958	SLEEP LAB	0	0	0	1,702,316	0.000000	76.07	
76.08	03640	UROLOGY	0	0	0	8,696	0.000000	76.08	
76.09	03959	ADDP OP	0	0	0	202,963	0.000000	76.09	
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	983,645	0.000000	76.10	
76.11	03960	DIABETES TREATMENT	0	0	0	110,704	0.000000	76.11	
76.12	03961	MENTAL HEALTH CENTER	0	0	0	512,491	0.000000	76.12	
76.13	03650	VEIN CLINIC	0	0	0	0	0.000000	76.13	
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,023,267	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	629,224	0.000000	90.01	
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0.000000	90.02	
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0.000000	90.03	
91.00	09100	EMERGENCY	0	0	0	64,030,354	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,200,562	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99	
200.00		Total (lines 50 through 199)	0	0	0	457,704,805		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-S158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 1:27 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	0	0	0	0	50.00
50.01	03340	GI LAB		0.000000	0	0	0	0	50.01
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
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	11,032	0	0	0	54.00
54.01	05401	MRI CENTER		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	9,286	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	17,708	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	123,121	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	466	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,092	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	995	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	61,265	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03951	EMG		0.000000	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0.000000	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0.000000	0	0	0	0	76.02
76.03	03954	MERCY ENT		0.000000	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0.000000	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0.000000	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0.000000	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0.000000	0	0	0	0	76.07
76.08	03640	UROLOGY		0.000000	0	0	0	0	76.08
76.09	03959	ADDP OP		0.000000	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0.000000	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0.000000	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0.000000	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0.000000	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0.000000	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0.000000	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.000000	175,021	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			399,986	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:

Worksheet D

Component CCN: 14-T158

From 07/01/2019
To 06/30/2020Part II
Date/Time Prepared:
1/28/2021 1:27 pm

				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,644,338	17,040,425	0.096496	46	4	50.00
50.01	03340	GI LAB	194,051	4,983,532	0.038938	3,393	132	50.01
51.00	05100	RECOVERY ROOM	41,083	2,004,735	0.020493	502	10	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	274,542	11,082,454	0.024773	0	0	52.00
53.00	05300	ANESTHESIOLOGY	16,888	4,415,097	0.003825	1,214	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	383,010	43,147,280	0.008877	34,034	302	54.00
54.01	05401	MRI CENTER	0	0	0.000000	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	15,271	6,091,162	0.002507	5,550	14	55.00
56.00	05600	RADIOISOTOPE	41,607	6,903,420	0.006027	1,422	9	56.00
57.00	05700	CT SCAN	35,820	40,808,759	0.000878	67,676	59	57.00
58.00	05800	MRI	1,041,422	8,126,988	0.128144	8,586	1,100	58.00
59.00	05900	CARDIAC CATHETERIZATION	291,935	30,225,908	0.009658	16,436	159	59.00
60.00	06000	LABORATORY	427,578	102,927,833	0.004154	242,644	1,008	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	73,920	14,179,650	0.005213	82,104	428	65.00
66.00	06600	PHYSICAL THERAPY	91,973	3,802,470	0.024188	536,646	12,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,607	2,291,035	0.015105	552,095	8,339	67.00
68.00	06800	SPEECH PATHOLOGY	25,677	1,700,973	0.015095	290,906	4,391	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,906	326,608	0.091565	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,195	6,110,552	0.017543	36,230	636	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,964	7,049,952	0.025811	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,766	59,278,659	0.001447	194,544	282	73.00
74.00	07400	RENAL DIALYSIS	16,828	1,636,031	0.010286	38,025	391	74.00
76.00	03951	EMG	0	0	0.000000	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0.000000	0	0	76.01
76.02	03953	MERCY EYE CENTER	70,142	900,551	0.077888	0	0	76.02
76.03	03954	MERCY ENT	0	0	0.000000	0	0	76.03
76.04	03955	WOUND CARE CENTER	14,809	902,461	0.016410	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0.000000	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	3,307	3,364,048	0.000983	0	0	76.06
76.07	03958	SLEEP LAB	2,301	1,702,316	0.001352	0	0	76.07
76.08	03640	UROLOGY	13,235	8,696	1.521964	0	0	76.08
76.09	03959	ADDP OP	744	202,963	0.003666	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	20,483	983,645	0.020824	0	0	76.10
76.11	03960	DIABETES TREATMENT	984	110,704	0.008889	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	2,964	512,491	0.005784	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0.000000	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	2,195	1,023,267	0.002145	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	532,044	629,224	0.845556	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0.000000	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	294,022	64,030,354	0.004592	4,872	22	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,200,562	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	6,012,611	457,704,805		2,116,925	30,271	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-T158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 1:27 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	03340	GI LAB		0	0	0	0	0	50.01
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
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	MRI CENTER		0	0	0	0	0	54.01
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	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03951	EMG		0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0	0	0	0	0	76.02
76.03	03954	MERCY ENT		0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0	0	0	0	0	76.07
76.08	03640	UROLOGY		0	0	0	0	0	76.08
76.09	03959	ADDP OP		0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0	0	0	0	0	90.03
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-T158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 1:27 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	17,040,425	0.000000	50.00
50.01	03340	GI LAB		0	0	0	4,983,532	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	2,004,735	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	11,082,454	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	4,415,097	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	43,147,280	0.000000	54.00
54.01	05401	MRI CENTER		0	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	6,091,162	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,903,420	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	40,808,759	0.000000	57.00
58.00	05800	MRI		0	0	0	8,126,988	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	30,225,908	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	102,927,833	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	14,179,650	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	3,802,470	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,291,035	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,700,973	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	326,608	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	6,110,552	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	7,049,952	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	59,278,659	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,636,031	0.000000	74.00
76.00	03951	EMG		0	0	0	0	0.000000	76.00
76.01	03952	CARDIOVASCULAR LAB		0	0	0	0	0.000000	76.01
76.02	03953	MERCY EYE CENTER		0	0	0	900,551	0.000000	76.02
76.03	03954	MERCY ENT		0	0	0	0	0.000000	76.03
76.04	03955	WOUND CARE CENTER		0	0	0	902,461	0.000000	76.04
76.05	03956	CARDIAC REHAB		0	0	0	0	0.000000	76.05
76.06	03957	PRE-BIRTH CENTER		0	0	0	3,364,048	0.000000	76.06
76.07	03958	SLEEP LAB		0	0	0	1,702,316	0.000000	76.07
76.08	03640	UROLOGY		0	0	0	8,696	0.000000	76.08
76.09	03959	ADDP OP		0	0	0	202,963	0.000000	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0	0	0	983,645	0.000000	76.10
76.11	03960	DIABETES TREATMENT		0	0	0	110,704	0.000000	76.11
76.12	03961	MENTAL HEALTH CENTER		0	0	0	512,491	0.000000	76.12
76.13	03650	VEIN CLINIC		0	0	0	0	0.000000	76.13
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,023,267	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0	0	0	629,224	0.000000	90.01
90.02	09002	MERCY CLINIC STATE ST		0	0	0	0	0.000000	90.02
90.03	09003	MERCY CLINIC POLK ST		0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY		0	0	0	64,030,354	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	9,200,562	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)		0	0	0	457,704,805		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-T158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 1:27 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	46	0	0	0	50.00
50.01	03340	GI LAB		0.000000	3,393	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	502	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	1,214	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	34,034	0	0	0	54.00
54.01	05401	MRI CENTER		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	5,550	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	1,422	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	67,676	0	0	0	57.00
58.00	05800	MRI		0.000000	8,586	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	16,436	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	242,644	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	82,104	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	536,646	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	552,095	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	290,906	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	36,230	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	194,544	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	38,025	0	0	0	74.00
76.00	03951	EMG		0.000000	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0.000000	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0.000000	0	0	0	0	76.02
76.03	03954	MERCY ENT		0.000000	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0.000000	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0.000000	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0.000000	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0.000000	0	0	0	0	76.07
76.08	03640	UROLOGY		0.000000	0	0	0	0	76.08
76.09	03959	ADDP OP		0.000000	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0.000000	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0.000000	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0.000000	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0.000000	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0.000000	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0.000000	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.000000	4,872	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			2,116,925	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
1/28/2021 1:27 pm

			Title XIX		Hospital	Cost		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,687,059	0	1,687,059	36,938	45.67	30.00	
31.00	INTENSIVE CARE UNIT	243,273		243,273	4,809	50.59	31.00	
32.00	CORONARY CARE UNIT	120,539		120,539	1,235	97.60	32.00	
32.01	NURSERY INTENSIVE CARE CENTER	49,415		49,415	1,041	47.47	32.01	
40.00	SUBPROVIDER - IPF	254,234	0	254,234	6,930	36.69	40.00	
41.00	SUBPROVIDER - IRF	115,723	0	115,723	2,725	42.47	41.00	
43.00	NURSERY	24,425		24,425	3,234	7.55	43.00	
200.00	Total (lines 30 through 199)	2,494,668		2,494,668	56,912		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,948	134,635					30.00
31.00	INTENSIVE CARE UNIT	470	23,777					31.00
32.00	CORONARY CARE UNIT	121	11,810					32.00
32.01	NURSERY INTENSIVE CARE CENTER	573	27,200					32.01
40.00	SUBPROVIDER - IPF	1,095	40,176					40.00
41.00	SUBPROVIDER - IRF	125	5,309					41.00
43.00	NURSERY	1,779	13,431					43.00
200.00	Total (lines 30 through 199)	7,111	256,338					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,644,338	0	0.000000	0	50.00
50.01	03340	GI LAB	194,051	0	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	41,083	0	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	274,542	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	16,888	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	383,010	0	0.000000	0	54.00
54.01	05401	MRI CENTER	0	0	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	15,271	0	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	41,607	0	0.000000	0	56.00
57.00	05700	CT SCAN	35,820	0	0.000000	0	57.00
58.00	05800	MRI	1,041,422	0	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	291,935	0	0.000000	0	59.00
60.00	06000	LABORATORY	427,578	0	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	73,920	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	91,973	0	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,607	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,677	0	0.000000	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,906	0	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,195	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,964	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,766	0	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	16,828	0	0.000000	0	74.00
76.00	03951	EMG	0	0	0.000000	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0.000000	0	76.01
76.02	03953	MERCY EYE CENTER	70,142	0	0.000000	0	76.02
76.03	03954	MERCY ENT	0	0	0.000000	0	76.03
76.04	03955	WOUND CARE CENTER	14,809	0	0.000000	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0.000000	0	76.05
76.06	03957	PRE-BIRTH CENTER	3,307	0	0.000000	0	76.06
76.07	03958	SLEEP LAB	2,301	0	0.000000	0	76.07
76.08	03640	UROLOGY	13,235	0	0.000000	0	76.08
76.09	03959	ADDP OP	744	0	0.000000	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	20,483	0	0.000000	0	76.10
76.11	03960	DIABETES TREATMENT	984	0	0.000000	0	76.11
76.12	03961	MENTAL HEALTH CENTER	2,964	0	0.000000	0	76.12
76.13	03650	VEIN CLINIC	0	0	0.000000	0	76.13
76.97	07697	CARDIAC REHABILITATION	2,195	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	532,044	0	0.000000	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0.000000	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0.000000	0	90.03
91.00	09100	EMERGENCY	294,022	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,978	0	0.000000	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	93.99
200.00		Total (lines 50 through 199)	6,322,589	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 1/28/2021 1:27 pm	
					Title XIX		Hospital		Cost	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	0	0	0	0	0	32.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	36,938	0.00	2,948	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	4,809	0.00	470	31.00		
32.00	03200	CORONARY CARE UNIT	0	0	1,235	0.00	121	32.00		
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	1,041	0.00	573	32.01		
40.00	04000	SUBPROVIDER - IPF	0	0	6,930	0.00	1,095	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	2,725	0.00	125	41.00		
43.00	04300	NURSERY	0	0	3,234	0.00	1,779	43.00		
200.00		Total (lines 30 through 199)	0	0	56,912		7,111	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
31.00	03100	INTENSIVE CARE UNIT	0							31.00
32.00	03200	CORONARY CARE UNIT	0							32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0							32.01
40.00	04000	SUBPROVIDER - IPF	0							40.00
41.00	04100	SUBPROVIDER - IRF	0							41.00
43.00	04300	NURSERY	0							43.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	03340	GI LAB	0	0	0	0	0	50.01
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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	0	0	0	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	0	0	0	0	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 1:27 pm	
				Title XIX		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0.000000	50.00
50.01	03340	GI LAB		0	0	0	0	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0.000000	54.00
54.01	05401	MRI CENTER		0	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
76.00	03951	EMG		0	0	0	0	0.000000	76.00
76.01	03952	CARDIOVASCULAR LAB		0	0	0	0	0.000000	76.01
76.02	03953	MERCY EYE CENTER		0	0	0	0	0.000000	76.02
76.03	03954	MERCY ENT		0	0	0	0	0.000000	76.03
76.04	03955	WOUND CARE CENTER		0	0	0	0	0.000000	76.04
76.05	03956	CARDIAC REHAB		0	0	0	0	0.000000	76.05
76.06	03957	PRE-BIRTH CENTER		0	0	0	0	0.000000	76.06
76.07	03958	SLEEP LAB		0	0	0	0	0.000000	76.07
76.08	03640	UROLOGY		0	0	0	0	0.000000	76.08
76.09	03959	ADDP OP		0	0	0	0	0.000000	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0	0	0	0	0.000000	76.10
76.11	03960	DIABETES TREATMENT		0	0	0	0	0.000000	76.11
76.12	03961	MENTAL HEALTH CENTER		0	0	0	0	0.000000	76.12
76.13	03650	VEIN CLINIC		0	0	0	0	0.000000	76.13
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0	0	0	0	0.000000	90.01
90.02	09002	MERCY CLINIC STATE ST		0	0	0	0	0.000000	90.02
90.03	09003	MERCY CLINIC POLK ST		0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY		0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)		0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description			Title XIX		Hospital	Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
50.01	03340	GI LAB	0.000000	0	0	0	0 50.01
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
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
54.01	05401	MRI CENTER	0.000000	0	0	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800	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	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.00	03951	EMG	0.000000	0	0	0	0 76.00
76.01	03952	CARDIOVASCULAR LAB	0.000000	0	0	0	0 76.01
76.02	03953	MERCY EYE CENTER	0.000000	0	0	0	0 76.02
76.03	03954	MERCY ENT	0.000000	0	0	0	0 76.03
76.04	03955	WOUND CARE CENTER	0.000000	0	0	0	0 76.04
76.05	03956	CARDIAC REHAB	0.000000	0	0	0	0 76.05
76.06	03957	PRE-BIRTH CENTER	0.000000	0	0	0	0 76.06
76.07	03958	SLEEP LAB	0.000000	0	0	0	0 76.07
76.08	03640	UROLOGY	0.000000	0	0	0	0 76.08
76.09	03959	ADDP OP	0.000000	0	0	0	0 76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0.000000	0	0	0	0 76.10
76.11	03960	DIABETES TREATMENT	0.000000	0	0	0	0 76.11
76.12	03961	MENTAL HEALTH CENTER	0.000000	0	0	0	0 76.12
76.13	03650	VEIN CLINIC	0.000000	0	0	0	0 76.13
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	0.000000	0	0	0	0 90.01
90.02	09002	MERCY CLINIC STATE ST	0.000000	0	0	0	0 90.02
90.03	09003	MERCY CLINIC POLK ST	0.000000	0	0	0	0 90.03
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 1:27 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)		36,938	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		36,938	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)		30,151	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)		9,133	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)		44,188,918	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)		44,188,918	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)		44,188,918	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)		1,196.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,925,808	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)		10,925,808	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
1/28/2021 1:27 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,276,269	4,809	1,928.94	1,525	2,941,634
44.00	CORONARY CARE UNIT	2,320,966	1,235	1,879.32	295	554,399
44.01	NURSERY INTENSIVE CARE CENTER	2,557,228	1,041	2,456.51	0	0
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					12,560,148
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,981,989
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					523,046
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					599,063
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,122,109
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					25,859,880
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					6,787
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,196.30
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,119,288

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
1/28/2021 1:27 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,687,059	44,188,918	0.038178	8,119,288	309,978	90.00
91.00 Nursing School cost	0	44,188,918	0.000000	8,119,288	0	91.00
92.00 Allied health cost	0	44,188,918	0.000000	8,119,288	0	92.00
93.00 All other Medical Education	0	44,188,918	0.000000	8,119,288	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1
		Component CCN: 14-S158		Date/Time Prepared: 1/28/2021 1:27 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)		6,930	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,930	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)		6,930	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)		928	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)		8,012,794	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)		8,012,794	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)		8,012,794	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)		1,156.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,073,000	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)		1,073,000	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1	
				Component CCN: 14-S158		Date/Time Prepared: 1/28/2021 1:27 pm	
				Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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	0	0	0.00	0	0	44.00
44.01	NURSERY INTENSIVE CARE CENTER	0	0	0.00	0	0	44.01
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)					86,882	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,159,882	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)					34,048	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,724	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					35,772	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,124,110	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0158 Component CCN: 14-S158		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 1/28/2021 1:27 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	254,234	8,012,794	0.031729	0	0	90.00
91.00	Nursing School cost	0	8,012,794	0.000000	0	0	91.00
92.00	Allied health cost	0	8,012,794	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,012,794	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 1:27 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,725	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,725	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)		2,725	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)		1,427	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)		4,032,367	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)		4,032,367	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)		4,032,367	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)		1,479.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,111,632	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,111,632	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1	
				Component CCN: 14-T158		Date/Time Prepared: 1/28/2021 1:27 pm	
				Title XVIII	Subprovider - IRF	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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
44.01	NURSERY INTENSIVE CARE CENTER	0	0	0.00	0	0	44.01
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)					910,039	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,021,671	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)					60,605	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					30,271	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					90,876	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,930,795	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0158 Component CCN: 14-T158		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 1/28/2021 1:27 pm
			Title XVIII		Subprovider - IRF		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	115,723	4,032,367	0.028699	0	0	90.00
91.00	Nursing School cost	0	4,032,367	0.000000	0	0	91.00
92.00	Allied health cost	0	4,032,367	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,032,367	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 1:27 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)		36,938	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		36,938	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)		30,151	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)		2,948	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)		3,234	15.00	
16.00	Nursery days (title V or XIX only)		1,779	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)		51,384,234	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)		51,384,234	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)		51,384,234	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)		1,391.09	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,100,933	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,100,933	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
1/28/2021 1:27 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)	1,133,176	3,234	350.39	1,779	623,344	42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	9,758,696	4,809	2,029.26	470	953,752	43.00	
44.00	CORONARY CARE UNIT	2,502,539	1,235	2,026.35	121	245,188	44.00	
44.01	NURSERY INTENSIVE CARE CENTER	2,912,421	1,041	2,797.71	573	1,603,088	44.01	
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)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						7,526,305	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)						6,787	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,391.09	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						9,441,328	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
1/28/2021 1:27 pm

		Title XIX		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,687,059	51,384,234	0.032832	9,441,328	309,978
91.00	Nursing School cost	0	51,384,234	0.000000	9,441,328	0
92.00	Allied health cost	0	51,384,234	0.000000	9,441,328	0
93.00	All other Medical Education	0	51,384,234	0.000000	9,441,328	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 1:27 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)			6,930 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			6,930 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)			6,930 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)			1,095 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)			3,234 15.00
16.00	Nursery days (title V or XIX only)			1,779 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)			8,012,794 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)			8,012,794 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)			8,012,794 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)			1,156.25 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,266,094 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)			1,266,094 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1	
				Component CCN: 14-S158		Date/Time Prepared: 1/28/2021 1:27 pm	
				Title XIX		Subprovider - IPF	Cost
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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	0	0	0.00	0	0	44.00
44.01	NURSERY INTENSIVE CARE CENTER	0	0	0.00	0	0	44.01
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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,266,094	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0158 Component CCN: 14-S158		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 1/28/2021 1:27 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		254,234	8,012,794	0.031729	0	0	90.00
91.00	Nursing School cost		0	8,012,794	0.000000	0	0	91.00
92.00	Allied health cost		0	8,012,794	0.000000	0	0	92.00
93.00	All other Medical Education		0	8,012,794	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 1:27 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,725 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,725 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)			2,725 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)			125 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			3,234 15.00
16.00	Nursery days (title V or XIX only)			1,779 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)			4,032,367 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)			4,032,367 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)			4,032,367 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)			1,479.77 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			184,971 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)			184,971 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1	
				Component CCN: 14-T158		Date/Time Prepared: 1/28/2021 1:27 pm	
				Title XIX		Subprovider - IRF	Cost
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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	0	0	0.00	0	0	44.00
44.01	NURSERY INTENSIVE CARE CENTER	0	0	0.00	0	0	44.01
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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					184,971	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:

Worksheet D-1

Component CCN: 14-T158

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/28/2021 1:27 pm

Title XIX

Subprovider -
IRF

Cost

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	115,723	4,032,367	0.028699	0	0	90.00
91.00	Nursing School cost	0	4,032,367	0.000000	0	0	91.00
92.00	Allied health cost	0	4,032,367	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,032,367	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 1:27 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		21,056,082	30.00
31.00	03100	INTENSIVE CARE UNIT		5,022,096	31.00
32.00	03200	CORONARY CARE UNIT		965,669	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER		0	32.01
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.641353	1,744,122	50.00
50.01	03340	GI LAB	0.322714	481,236	50.01
51.00	05100	RECOVERY ROOM	0.610483	251,944	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.635485	18,248	52.00
53.00	05300	ANESTHESIOLOGY	0.124472	357,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175676	3,841,442	54.00
54.01	05401	MRI CENTER	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198163	148,553	55.00
56.00	05600	RADIOISOTOPE	0.172481	437,236	56.00
57.00	05700	CT SCAN	0.046137	4,861,390	57.00
58.00	05800	MRI	0.120089	849,993	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.190611	5,472,634	59.00
60.00	06000	LABORATORY	0.153175	14,903,793	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.209635	4,401,952	65.00
66.00	06600	PHYSICAL THERAPY	0.597277	521,613	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.497112	227,394	67.00
68.00	06800	SPEECH PATHOLOGY	0.410706	279,578	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.850748	67,820	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.552361	1,525,111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.704795	1,049,961	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.394207	5,307,298	73.00
74.00	07400	RENAL DIALYSIS	0.717434	616,543	74.00
76.00	03951	EMG	0.000000	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0.000000	0	76.01
76.02	03953	MERCY EYE CENTER	0.887487	0	76.02
76.03	03954	MERCY ENT	0.000000	0	76.03
76.04	03955	WOUND CARE CENTER	0.627377	1,854	76.04
76.05	03956	CARDIAC REHAB	0.000000	0	76.05
76.06	03957	PRE-BIRTH CENTER	0.185296	0	76.06
76.07	03958	SLEEP LAB	0.403019	0	76.07
76.08	03640	UROLOGY	21.982176	0	76.08
76.09	03959	ADDP OP	0.822672	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0.142883	0	76.10
76.11	03960	DIABETES TREATMENT	2.215394	0	76.11
76.12	03961	MENTAL HEALTH CENTER	1.126623	0	76.12
76.13	03650	VEIN CLINIC	0.000000	0	76.13
76.97	07697	CARDIAC REHABILITATION	0.457296	170	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	MERCY CLINICS	18.349028	730	90.01
90.02	09002	MERCY CLINIC STATE ST	0.000000	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0.000000	0	90.03
91.00	09100	EMERGENCY	0.211242	4,571,820	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.882477	30,638	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,970,406	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)		51,970,406	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 1:27 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
32.00	03200 CORONARY CARE UNIT		0		32.00
32.01	02060 NURSERY INTENSIVE CARE CENTER		0		32.01
40.00	04000 SUBPROVIDER - IPF		1,719,544		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.641353	0	0	50.00
50.01	03340 GI LAB	0.322714	0	0	50.01
51.00	05100 RECOVERY ROOM	0.610483	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.635485	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.124472	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175676	11,032	1,938	54.00
54.01	05401 MRI CENTER	0.000000	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.198163	0	0	55.00
56.00	05600 RADIOISOTOPE	0.172481	0	0	56.00
57.00	05700 CT SCAN	0.046137	9,286	428	57.00
58.00	05800 MRI	0.120089	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.190611	17,708	3,375	59.00
60.00	06000 LABORATORY	0.153175	123,121	18,859	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.209635	466	98	65.00
66.00	06600 PHYSICAL THERAPY	0.597277	1,092	652	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.497112	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.410706	995	409	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.850748	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.552361	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.704795	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.394207	61,265	24,151	73.00
74.00	07400 RENAL DIALYSIS	0.717434	0	0	74.00
76.00	03951 EMG	0.000000	0	0	76.00
76.01	03952 CARDIOVASCULAR LAB	0.000000	0	0	76.01
76.02	03953 MERCY EYE CENTER	0.887487	0	0	76.02
76.03	03954 MERCY ENT	0.000000	0	0	76.03
76.04	03955 WOUND CARE CENTER	0.627377	0	0	76.04
76.05	03956 CARDIAC REHAB	0.000000	0	0	76.05
76.06	03957 PRE-BIRTH CENTER	0.185296	0	0	76.06
76.07	03958 SLEEP LAB	0.403019	0	0	76.07
76.08	03640 UROLOGY	21.982176	0	0	76.08
76.09	03959 ADDP OP	0.822672	0	0	76.09
76.10	03550 PSYCH PARTIAL HOSPITAL	0.142883	0	0	76.10
76.11	03960 DIABETES TREATMENT	2.215394	0	0	76.11
76.12	03961 MENTAL HEALTH CENTER	1.126623	0	0	76.12
76.13	03650 VEIN CLINIC	0.000000	0	0	76.13
76.97	07697 CARDIAC REHABILITATION	0.457296	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 MERCY CLINICS	18.349028	0	0	90.01
90.02	09002 MERCY CLINIC STATE ST	0.000000	0	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.211242	175,021	36,972	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.882477	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		399,986	86,882	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)		399,986		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 1:27 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
32.01	02060 NURSERY INTENSIVE CARE CENTER		0		32.01
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,640,833		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.641353	46	30	50.00
50.01	03340 GI LAB	0.322714	3,393	1,095	50.01
51.00	05100 RECOVERY ROOM	0.610483	502	306	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.635485	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.124472	1,214	151	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175676	34,034	5,979	54.00
54.01	05401 MRI CENTER	0.000000	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.198163	5,550	1,100	55.00
56.00	05600 RADIOISOTOPE	0.172481	1,422	245	56.00
57.00	05700 CT SCAN	0.046137	67,676	3,122	57.00
58.00	05800 MRI	0.120089	8,586	1,031	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.190611	16,436	3,133	59.00
60.00	06000 LABORATORY	0.153175	242,644	37,167	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.209635	82,104	17,212	65.00
66.00	06600 PHYSICAL THERAPY	0.597277	536,646	320,526	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.497112	552,095	274,453	67.00
68.00	06800 SPEECH PATHOLOGY	0.410706	290,906	119,477	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.850748	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.552361	36,230	20,012	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.704795	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.394207	194,544	76,691	73.00
74.00	07400 RENAL DIALYSIS	0.717434	38,025	27,280	74.00
76.00	03951 EMG	0.000000	0	0	76.00
76.01	03952 CARDIOVASCULAR LAB	0.000000	0	0	76.01
76.02	03953 MERCY EYE CENTER	0.887487	0	0	76.02
76.03	03954 MERCY ENT	0.000000	0	0	76.03
76.04	03955 WOUND CARE CENTER	0.627377	0	0	76.04
76.05	03956 CARDIAC REHAB	0.000000	0	0	76.05
76.06	03957 PRE-BIRTH CENTER	0.185296	0	0	76.06
76.07	03958 SLEEP LAB	0.403019	0	0	76.07
76.08	03640 UROLOGY	21.982176	0	0	76.08
76.09	03959 ADDP OP	0.822672	0	0	76.09
76.10	03550 PSYCH PARTIAL HOSPITAL	0.142883	0	0	76.10
76.11	03960 DIABETES TREATMENT	2.215394	0	0	76.11
76.12	03961 MENTAL HEALTH CENTER	1.126623	0	0	76.12
76.13	03650 VEIN CLINIC	0.000000	0	0	76.13
76.97	07697 CARDIAC REHABILITATION	0.457296	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 MERCY CLINICS	18.349028	0	0	90.01
90.02	09002 MERCY CLINIC STATE ST	0.000000	0	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.211242	4,872	1,029	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.882477	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,116,925	910,039	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)		2,116,925		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/28/2021 1:27 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)			4,648,060 1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			13,999,792 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)			
2.01	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)			134,486 2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			403,457 2.04
3.00	Managed Care Simulated Payments			11,843,009 3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			183.90 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)			87.01 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).			-2.25 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)			16.00 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)			100.76 9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			102.53 10.00
11.00	FTE count for residents in dental and podiatric programs.			6.00 11.00
12.00	Current year allowable FTE (see instructions)			106.76 12.00
13.00	Total allowable FTE count for the prior year.			106.76 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.			106.76 14.00
15.00	Sum of lines 12 through 14 divided by 3.			106.76 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			106.76 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.580533 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.578974 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.578974 21.00
22.00	IME payment adjustment (see instructions)			5,115,758 22.00
22.01	IME payment adjustment - Managed Care (see instructions)			3,248,952 22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00 23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			1.77 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)			5,115,758 29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			3,248,952 29.01
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			15.84 30.00
31.00	Percentage of Medicaid patient days (see instructions)			41.38 31.00
32.00	Sum of lines 30 and 31			57.22 32.00
33.00	Allowable disproportionate share percentage (see instructions)			36.42 33.00
34.00	Disproportionate share adjustment (see instructions)			1,697,887 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/28/2021 1:27 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,582,259	2,193,466	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	902,926	1,642,103	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,545,029		36.00
40.00	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	28,544,469		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)		31,793,421	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,179,670	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).		3,500,092	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		37,473,183	59.00
60.00	Primary payer payments		37,094	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		37,436,089	61.00
62.00	Deductibles billed to program beneficiaries		1,834,419	62.00
63.00	Coinsurance billed to program beneficiaries		185,595	63.00
64.00	Allowable bad debts (see instructions)		570,296	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		370,692	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		570,296	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		35,786,767	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)		-113,769	70.93
70.94	HRR adjustment amount (see instructions)		-226,669	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/28/2021 1:27 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)		336,327	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		35,110,002	71.00
71.01	Sequestration adjustment (see instructions)		586,337	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		36,137,194	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-1,613,529	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		709,536	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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/28/2021 1:27 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	4,648,060	4,648,060		4,648,060	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,999,792		13,999,792	13,999,792	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	134,486	134,486		134,486	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	403,457		403,457	403,457	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	11,843,009	2,960,752	8,882,257	11,843,009	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.578974	0.578974	0.578974		5.00
6.00	IME payment adjustment (see instructions)	22.00	5,115,758	1,275,126	3,840,632	5,115,758	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	3,248,952	812,238	2,436,714	3,248,952	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	5,115,758	1,275,126	3,840,632	5,115,758	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	3,248,952	812,238	2,436,714	3,248,952	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3642	0.3642	0.3642		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,697,887	423,206	1,274,681	1,697,887	11.00
11.01	Uncompensated care payments	36.00	2,545,029	902,926	1,642,103	2,545,029	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	28,544,469	7,383,804	21,160,665	28,544,469	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	31,793,421	8,196,042	23,597,379	31,793,421	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,179,670	544,919	1,634,751	2,179,670	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,740,961	25,232,130	33,973,091	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/28/2021 1:27 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,476,283	369,071	1,107,212	1,476,283	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	22,378	5,595	16,783	22,378	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	0.3384	0.3384	0.3384		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	499,574	124,894	374,680	499,574	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1229	0.1229	0.1229		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	181,435	45,359	136,076	181,435	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,179,670	544,919	1,634,751	2,179,670	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	-113,769	-47,903	-65,866	-113,769	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	-226,669	-33,769	-192,900	-226,669	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		86,593	249,734	336,327	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Health Financial Systems		MERCY HOSPITAL & MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/28/2021 1:27 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			6,955	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			15,255,912	2.00
3.00	OPPS payments			10,280,670	3.00
4.00	Outlier payment (see instructions)			31,507	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,955	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			17,643	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)			17,643	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)			17,643	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			10,688	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)			6,955	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)			10,312,177	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,031,805	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)			8,287,327	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			1,716,257	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)			10,003,584	30.00
31.00	Primary payer payments			135	31.00
32.00	Subtotal (line 30 minus line 31)			10,003,449	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)			373,034	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			242,472	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			373,034	36.00
37.00	Subtotal (see instructions)			10,245,921	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)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			10,245,921	40.00
40.01	Sequestration adjustment (see instructions)			171,107	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			10,238,035	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)			-163,221	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/28/2021 1:27 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 OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	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)		0.850	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	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)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	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		0	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)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems		MERCY HOSPITAL & MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2019	Worksheet E	
		Component CCN: 14-T158	To 06/30/2020	Part B	
		Title XVIII	Subprovider - IRF	Date/Time Prepared: 1/28/2021 1:27 pm	
				PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3.00	OPPS payments			0	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)			0.850	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			0	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)			0	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			0	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)			0	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)			0	40.00
40.01	Sequestration adjustment (see instructions)			0	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			0	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)			0	43.00
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
1/28/2021 1:27 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		37,443,627		10,099,162	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	02/11/2020	138,873	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	02/11/2020	1,306,433		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)		-1,306,433		138,873	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)		36,137,194		10,238,035	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		1,613,529		163,221	6.02	
7.00	Total Medicare program liability (see instructions)		34,523,665		10,074,814	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0158 Component CCN: 14-S158		Period: From 07/01/2019 To 06/30/2020		Worksheet E-1 Part I Date/Time Prepared: 1/28/2021 1:27 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		727,230		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		727,230		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		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		727,230		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0158
 Component CCN: 14-T158

 Period:
 From 07/01/2019
 To 06/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 1/28/2021 1:27 pm

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,967,811		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,967,811		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		11,846		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,979,657		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
1/28/2021 1:27 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part II Date/Time Prepared: 1/28/2021 1:27 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)			884,726 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see 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)			18.934426 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)			884,726 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)			884,726 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			884,726 18.00
19.00	Deductibles			86,020 19.00
20.00	Subtotal (line 18 minus line 19)			798,706 20.00
21.00	Coinurance			59,125 21.00
22.00	Subtotal (line 20 minus line 21)			739,581 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			739,581 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			739,581 31.00
31.01	Sequestration adjustment (see instructions)			12,351 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			727,230 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)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part III Date/Time Prepared: 1/28/2021 1:27 pm
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		2,737,938	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.1747	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		290,769	3.00
4.00	Outlier Payments		17,329	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		1.23	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		7.445355	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		3,046,036	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		3,046,036	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		3,046,036	19.00
20.00	Deductibles		15,092	20.00
21.00	Subtotal (line 19 minus line 20)		3,030,944	21.00
22.00	Coinsurance		682	22.00
23.00	Subtotal (line 21 minus line 22)		3,030,262	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		3,030,262	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		3,030,262	32.00
32.01	Sequestration adjustment (see instructions)		50,605	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		2,967,811	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		11,846	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		17,329	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 1/28/2021 1:27 pm
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	7,526,305		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	7,526,305	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	7,526,305	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	2,459,906		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,459,906	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,459,906	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	5,066,399	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2,459,906	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	2,459,906	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	5,066,399	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,459,906	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,459,906	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,459,906	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2,459,906	0	40.00
41.00	Interim payments	2,459,906	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 1/28/2021 1:27 pm
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	1,266,094		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,266,094	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,266,094	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,266,094	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	1,266,094	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 1/28/2021 1:27 pm	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		184,971		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		184,971	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		184,971	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		184,971	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		184,971	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS
Provider CCN: 14-0158
Period: From 07/01/2019 To 06/30/2020
Worksheet E-4
Date/Time Prepared: 1/28/2021 1:27 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.		88.01	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))		-2.25	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)		0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)		17.00	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)		102.76	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		102.53	6.00
7.00	Enter the lesser of line 5 or line 6		102.53	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.	72.80	28.64	101.44	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.	72.80	28.64	101.44	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		6.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	72.80	34.64		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	73.64	33.25		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	72.80	31.83		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	73.08	33.24		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	73.08	33.24		17.00
18.00	Per resident amount	114,665.98	108,577.85		18.00
19.00	Approved amount for resident costs	8,379,790	3,609,128	11,988,918	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)	11,988,918	25.00

	Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
	1.00	2.00	2.01	3.00	

COMPUTATION OF PROGRAM PATIENT LOAD						
26.00	Inpatient Days (see instructions)	13,308	1,973	5,919		26.00
27.00	Total Inpatient Days (see instructions)	47,455	47,455	47,455		27.00
28.00	Ratio of inpatient days to total inpatient days	0.280434	0.041576	0.124729		28.00
29.00	Program direct GME amount	3,362,100	498,451	1,495,366	5,355,917	29.00
29.01	Percent reduction for MA DGME		7.00	7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		34,892	104,676	139,568	30.00
31.00	Net Program direct GME amount				5,216,349	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 1/28/2021 1:27 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)			1,636,031	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)			31,163,542	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)			37,094	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			31,126,448	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			15,262,867	42.00
43.00	Primary payer payments (see instructions)			135	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			15,262,732	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			46,389,180	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.670985	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.329015	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			5,216,349	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			3,500,092	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			1,716,257	50.00

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

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
1/28/2021 1:27 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	1,985,670	0	0	0	1.00
2.00	Temporary investments	13,365,831	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	25,880,295	0	0	0	4.00
5.00	Other receivable	1,404,793	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,340,112	0	0	0	7.00
8.00	Prepaid expenses	2,403,270	0	0	0	8.00
9.00	Other current assets	1,282,000	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)	49,661,971	0	0	0	11.00
FIXED ASSETS						
12.00	Land	25,260,430	0	0	0	12.00
13.00	Land improvements	7,313	0	0	0	13.00
14.00	Accumulated depreciation	-5,106	0	0	0	14.00
15.00	Buildings	3,687,232	0	0	0	15.00
16.00	Accumulated depreciation	-261,388	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,696,875	0	0	0	23.00
24.00	Accumulated depreciation	-1,836,882	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)	32,548,474	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	993,099	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	993,099	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	83,203,544	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,831,993	0	0	0	37.00
38.00	Salaries, wages, and fees payable	93,227,367	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,459,659	0	0	0	40.00
41.00	Deferred income	76,591	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	8,490,966	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	113,086,576	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	75,625,691	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	75,625,691	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	188,712,267	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-105,508,723	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-105,508,723	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	83,203,544	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
1/28/2021 1:27 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		-104,730,644		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,000,431				2.00
3.00	Total (sum of line 1 and line 2)		-100,730,213		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-100,730,213		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS	4,778,510		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)		4,778,510		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-105,508,723		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFERS		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
1/28/2021 1:27 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	72,722,462		72,722,462	1.00
2.00	SUBPROVIDER - IPF	12,842,740		12,842,740	2.00
3.00	SUBPROVIDER - IRF	5,083,325		5,083,325	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	90,648,527		90,648,527	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,949,203		15,949,203	11.00
12.00	CORONARY CARE UNIT	3,030,259		3,030,259	12.00
12.01	NURSERY INTENSIVE CARE CENTER	7,573,127		7,573,127	12.01
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)	26,552,589		26,552,589	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	117,201,116		117,201,116	17.00
18.00	Ancillary services	187,433,227	267,858,765	455,291,992	18.00
19.00	Outpatient services	0	2,412,813	2,412,813	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
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS AND OTHER NON HOSPITAL RE	0	79,526,551	79,526,551	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	304,634,343	349,798,129	654,432,472	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		268,250,099		29.00
30.00	NON OPERATING EXPENSES	-550,727			30.00
31.00	NON OPERATING REVENUE	-23,971			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)		-574,698		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)		267,675,401		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
1/28/2021 1:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	654,432,472	1.00
2.00	Less contractual allowances and discounts on patients' accounts	399,389,164	2.00
3.00	Net patient revenues (line 1 minus line 2)	255,043,308	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	267,675,401	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,632,093	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	104,737	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	642,278	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER RENT REVENUE	760,981	24.00
24.01	CAPITATION REVENUE AND MGD CARE DIS	2,589,218	24.01
24.02	GRANTS	1,749,046	24.02
24.03	INTER COMPNAY TRWASURY REVENUE	-3,177,099	24.03
24.04	REFERRAL LAB	126,503	24.04
24.05	CONTRACT REVENUE	170,055	24.05
24.06	CMS 2% DISCOUNT	232,833	24.06
24.07	MISCELLANEOUS REVENUE	733,972	24.07
24.08	OTHER (SPECIFY)	0	24.08
24.09	OTHER (SPECIFY)	0	24.09
24.10	OTHER (SPECIFY)	0	24.10
24.11	OTHER (SPECIFY)	0	24.11
24.12	OTHER (SPECIFY)	0	24.12
24.13	OTHER (SPECIFY)	0	24.13
24.50	COVID-19 PHE Funding	12,700,000	24.50
25.00	Total other income (sum of lines 6-24)	16,632,524	25.00
26.00	Total (line 5 plus line 25)	4,000,431	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)	4,000,431	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0158	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 1/28/2021 1:27 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,476,283	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		22,378	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)		103.37	3.00
4.00	Number of interns & residents (see instructions)		106.76	4.00
5.00	Indirect medical education percentage (see instructions)		33.84	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)		499,574	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		15.84	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		41.38	8.00
9.00	Sum of lines 7 and 8		57.22	9.00
10.00	Allowable disproportionate share percentage (see instructions)		12.29	10.00
11.00	Disproportionate share adjustment (see instructions)		181,435	11.00
12.00	Total prospective capital payments (see instructions)		2,179,670	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