

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: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/30/2020 2:16 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 6/30/2020 Time: 2:16 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 COMMUNITY HOSPITAL OF INDIANA, INC. (15-0169) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) HOLLY MILLARD
Officer or Administrator of Provider(s)

NETWORK SR VP FINANCE
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	386,791	167,882	0	0	1.00
2.00 Subprovider - IPF	0	9,783	-10		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	396,574	167,872	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: 15-0169		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/30/2020 2:16 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00 Street: 7150 CLEARVISTA DRIVE		PO Box:										
2.00 City: INDIANAPOLIS		State: IN		Zip Code: 46256		County: MARION						
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
				V	XVIII	XIX						
Hospital and Hospital-Based Component Identification:												
3.00 Hospital		COMMUNITY HOSPITAL OF INDIANA, INC.		150169	26900	1	02/25/2008	N	P	P	3.00	
4.00 Subprovider - IPF		COMMUNITY MENTAL HEALTH		15S169	26900	4	01/01/2010	N	P	O	4.00	
5.00 Subprovider - IRF											5.00	
6.00 Subprovider - (Other)											6.00	
7.00 Swing Beds - SNF											7.00	
8.00 Swing Beds - NF											8.00	
9.00 Hospital-Based SNF											9.00	
10.00 Hospital-Based NF											10.00	
11.00 Hospital-Based OLTC											11.00	
12.00 Hospital-Based HHA											12.00	
13.00 Separately Certified ASC											13.00	
14.00 Hospital-Based Hospice											14.00	
15.00 Hospital-Based Health Clinic - RHC											15.00	
16.00 Hospital-Based Health Clinic - FQHC											16.00	
17.00 Hospital-Based (CMHC) I											17.00	
18.00 Renal Dialysis											18.00	
19.00 Other											19.00	
							From:	To:				
							1.00	2.00				
20.00 Cost Reporting Period (mm/dd/yyyy)							01/01/2019	12/31/2019		20.00		
21.00 Type of Control (see instructions)							2			21.00		
							1.00	2.00	3.00			
Inpatient PPS Information												
22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N				22.00	
22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y				22.01	
22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N				22.02	
22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N	N			22.03	
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N				23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		4,527	2,133	0	14	20,151	55				24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/30/2020 2:16 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y		40.00
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))				
	1.00	2.00	3.00	4.00	5.00				
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000			65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))				
			1.00	2.00	3.00				
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		0.00	4.66	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)	FAMILY PRACTICE	1350	0.00	1.49	0.000000			67.00
					1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y			70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00	
					Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N			75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N		0	76.00	

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						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.06	
Rural Providers									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					N	N	N	N
						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: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/30/2020 2:16 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		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	788,234	0	118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/30/2020 2:16 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: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 08101	
142.00	Street: 1500 NORTH RITTER AVENUE	PO Box:			
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46219-3095	
144.00 Are provider based physicians' costs included in Worksheet A?					
				1.00	
				Y	
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.					
				1.00	
				Y	
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.					
				2.00	
				N	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					
		Part A		Part B	
		Title V		Title XIX	
		1.00		2.00	
		3.00		4.00	
155.00 Hospital					
		N		N	
156.00 Subprovider - IPF					
		N		N	
157.00 Subprovider - IRF					
		N		N	
158.00 SUBPROVIDER					
		N		N	
159.00 SNF					
		N		N	
160.00 HOME HEALTH AGENCY					
		N		N	
161.00 CMHC					
		N		N	
Multi campus					
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					
				1.00	
				N	
		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	
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.					
				1.00	
				Y	
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)					
				168.01	
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)					
				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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					
				N	
				0	
				171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 6/30/2020 2:16 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				
		1.00	2.00				
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				
		1.00	2.00				
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.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	06/26/2020	Y	06/26/2020		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/30/2020 2:16 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		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved 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.	SHIRLEY		BISHOP	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0169

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

Worksheet S-2
Part II
Date/Time Prepared:
6/30/2020 2:16 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.	DI RECTOR REIMBURSEMENT	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: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
6/30/2020 2:16 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	238	86,870	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)		238	86,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	35.00	48	17,520	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		310	113,150	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		328				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: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
6/30/2020 2:16 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	18,645	2,470	57,497			1.00
2.00 HMO and other (see instructions)	9,559	19,857				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	18,645	2,470	57,497			7.00
8.00 INTENSIVE CARE UNIT	2,102	0	6,544			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	0	1,717	11,655			12.00
13.00 NURSERY		2,781	7,388			13.00
14.00 Total (see instructions)	20,747	6,968	83,084	4.40	1,539.36	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,786	0	5,142	1.74	26.66	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						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)			407			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				6.14	1,566.02	27.00
28.00 Observation Bed Days		2,023	7,651			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			2,265			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	55	1,399			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: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
6/30/2020 2:16 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
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	4,516	500	17,426	1.00
2.00	HMO and other (see instructions)			1,772	2,824		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	4,516	500	17,426	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	252	0	495	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3
Part II
Date/Time Prepared:
6/30/2020 2:16 pm

	Wkst. A Line Number	Amount Reported	Reclassification 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	107,915,223	-586,529	107,328,694	3,257,322.00	32.95
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		357,850	0	357,850	1,968.00	181.83
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		489,852	0	489,852	8,406.00	58.27
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,830,748	-14,710	2,816,038	85,186.00	33.06
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		2,048,742	0	2,048,742	20,502.00	99.93
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		1,995,259	0	1,995,259	17,518.00	113.90
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		34,137,040	0	34,137,040	840,515.00	40.61
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)		26,681,540	0	26,681,540		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		720,524	0	720,524		
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		20,699	0	20,699		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		89,327	0	89,327		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		8,354,416	0	8,354,416		
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: 15-0169

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

Worksheet S-3
Part II
Date/Time Prepared:
6/30/2020 2:16 pm

	Wkst. A Line Number	Amount Reported	Reclassification 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	164,743	0	164,743	3,438.00	47.92	26.00
27.00	Administrative & General	5,603,979	-16,666	5,587,313	146,103.00	38.24	27.00
28.00	Administrative & General under contract (see inst.)	7,658,877	0	7,658,877	86,237.00	88.81	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	3,183,469	-22,842	3,160,627	138,772.00	22.78	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	3,043,122	-24,885	3,018,237	195,696.00	15.42	32.00
33.00	Housekeeping under contract (see instructions)	394,740	0	394,740	9,911.00	39.83	33.00
34.00	Dietary	2,543,776	-1,909,543	634,233	36,046.00	17.60	34.00
35.00	Dietary under contract (see instructions)	509,158	0	509,158	6,240.00	81.60	35.00
36.00	Cafeteria	0	1,893,968	1,893,968	105,063.00	18.03	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	2,349,276	-9,217	2,340,059	65,746.00	35.59	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	6,880,207	-1,896,268	4,983,939	119,105.00	41.84	40.00
41.00	Medical Records & Medical Records Library	377,831	-7,963	369,868	9,246.00	40.00	41.00
42.00	Social Service	1,717,727	-9,015	1,708,712	44,670.00	38.25	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3
Part III
Date/Time Prepared:
6/30/2020 2:16 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati 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)	115,988,146	-586,529	115,401,617	3,351,304.00	34.43	1.00
2.00	Excluded area salaries (see instructions)	2,830,748	-14,710	2,816,038	85,186.00	33.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	113,157,398	-571,819	112,585,579	3,266,118.00	34.47	3.00
4.00	Subtotal other wages & related costs (see inst.)	38,181,041	0	38,181,041	878,535.00	43.46	4.00
5.00	Subtotal wage-related costs (see inst.)	35,056,655	0	35,056,655	0.00	31.14	5.00
6.00	Total (sum of lines 3 thru 5)	186,395,094	-571,819	185,823,275	4,144,653.00	44.83	6.00
7.00	Total overhead cost (see instructions)	34,426,905	-2,002,431	32,424,474	966,273.00	33.56	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 6/30/2020 2:16 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			3,618,376 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)			3,219 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			252,151 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			11,511,973 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			2,942,858 9.00
10.00	Dental, Hearing and Vision Plan			114,401 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			64,635 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)			900,600 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			250,043 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			7,693,134 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			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			157,703 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			27,509,093 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part V Date/Time Prepared: 6/30/2020 2:16 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,048,742	27,509,093	1.00
2.00	Hospital	2,048,742	26,788,569	2.00
3.00	Subprovider - IPF	0	507,455	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	213,069	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/30/2020 2:16 pm
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			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)		0.224038	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		91,861,742	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		282,150,585	6.00
7.00	Medicaid cost (line 1 times line 6)		63,212,453	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)	28,040,446	3,703,331	31,743,777
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	6,282,125	3,703,331	9,985,456
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	6,282,125	3,703,331	9,985,456
			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)		25,766,464	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		582,246	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		895,762	27.01
28.00	Non-Medicare bad debt expense (see instructions)		24,870,702	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		5,885,498	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		15,870,954	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		15,870,954	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

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

Worksheet A
Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	0	0	22,320,308	22,320,308	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	10,368,680	10,368,680	2.00	
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	164,743	276,171	440,914	-113,136	327,778	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,603,979	153,067,373	158,671,352	-21,865,321	136,806,031	5.00
7.00	00700	OPERATION OF PLANT	3,183,469	7,845,985	11,029,454	-187,361	10,842,093	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	984,338	984,338	-80	984,258	8.00
9.00	00900	HOUSEKEEPING	3,043,122	1,876,486	4,919,608	-24,440	4,895,168	9.00
10.00	01000	DIETARY	2,543,776	2,955,449	5,499,225	-4,117,309	1,381,916	10.00
11.00	01100	CAFETERIA	0	0	0	4,027,812	4,027,812	11.00
13.00	01300	NURSING ADMINISTRATION	2,349,276	666,785	3,016,061	-12,398	3,003,663	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,054,637	2,054,637	-2,625,241	-570,604	14.00
15.00	01500	PHARMACY	6,880,207	22,246,927	29,127,134	-23,780,993	5,346,141	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	377,831	64,744	442,575	-80	442,495	16.00
17.00	01700	SOCIAL SERVICE	1,717,727	456,245	2,173,972	-478	2,173,494	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,363,184	17,098,348	51,461,532	-12,166,904	39,294,628	30.00
31.00	03100	INTENSIVE CARE UNIT	4,722,814	2,258,675	6,981,489	-819,703	6,161,786	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,427,147	2,960,703	9,387,850	-457,065	8,930,785	35.00
40.00	04000	SUBPROVIDER - I PF	1,905,425	690,649	2,596,074	-22,848	2,573,226	40.00
43.00	04300	NURSERY	0	0	0	2,221,741	2,221,741	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,227,675	33,410,719	38,638,394	-27,563,456	11,074,938	50.00
51.00	05100	RECOVERY ROOM	2,429,083	1,287,773	3,716,856	-282,429	3,434,427	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	190,819	79,833	270,652	6,129,288	6,399,940	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,509,146	2,095,877	5,605,023	-1,406,271	4,198,752	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	502,296	3,297,316	3,799,612	-2,865,533	934,079	55.00
57.00	05700	CT SCAN	915,227	926,068	1,841,295	-331,617	1,509,678	57.00
58.00	05800	MRI	485,303	833,720	1,319,023	-416,489	902,534	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,935	1,935	-1,803	132	59.00
60.00	06000	LABORATORY	0	10,853,469	10,853,469	-31	10,853,438	60.00
64.00	06400	INTRAVENOUS THERAPY	623,553	312,944	936,497	-88,159	848,338	64.00
65.00	06500	RESPIRATORY THERAPY	2,932,614	1,724,089	4,656,703	-604,637	4,052,066	65.00
66.00	06600	PHYSICAL THERAPY	6,276,416	3,193,335	9,469,751	-2,805,584	6,664,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,883,020	1,883,020	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	322,226	322,226	68.00
69.00	06900	ELECTROCARDIOLOGY	31,938	756,651	788,589	-3,589	785,000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	992,982	788,598	1,781,580	-190,231	1,591,349	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,558,640	20,558,640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,538,159	14,538,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,786,277	16,786,277	73.00
73.01	07301	SPECIALTY PHARMACY	0	7,616,688	7,616,688	9,728,231	17,344,919	73.01
74.00	07400	RENAL DIALYSIS	0	1,388,040	1,388,040	-1,859	1,386,181	74.00
76.00	03330	ENDOSCOPY	1,225,449	2,632,587	3,858,036	-1,862,139	1,995,897	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	189,246	54,554	243,800	-18,598	225,202	76.04
76.06	03954	IMAGING CENTER	1,598,003	2,602,202	4,200,205	-676,815	3,523,390	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	9,461,380	9,461,380	-14,086	9,447,294	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	103,638	3,056,862	3,160,500	-2,941,585	218,915	90.01
90.26	04975	SPINE CENTER	192,075	64,769	256,844	-482	256,362	90.26
91.00	09100	EMERGENCY	6,281,737	3,388,440	9,670,177	-601,009	9,069,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,989,900	305,331,364	412,321,264	14,623	412,335,887	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	95,996	95,996	0	95,996	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	38,771	38,771	-12,945	25,826	194.06
194.08	07958	OTHER NRCC	925,323	443,240	1,368,563	-1,678	1,366,885	194.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019	Worksheet A Date/Time Prepared: 6/30/2020 2:16 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)
		1.00	2.00	3.00	4.00	5.00
194.10	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0
200.00	TOTAL (SUM OF LINES 118 through 199)	107,915,223	305,909,371	413,824,594	0	413,824,594
						194.10
						200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

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

Worksheet A
Date/Time Prepared:
6/30/2020 2:16 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	-7,718,863	14,601,445	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,633,008	16,001,688	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,597,440	4,925,218	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-73,983,313	62,822,718	5.00
7.00	00700	OPERATION OF PLANT	600,141	11,442,234	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	984,258	8.00
9.00	00900	HOUSEKEEPING	0	4,895,168	9.00
10.00	01000	DIETARY	-20,163	1,361,753	10.00
11.00	01100	CAFETERIA	-2,702,390	1,325,422	11.00
13.00	01300	NURSING ADMINISTRATION	5,065,167	8,068,830	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,449,201	878,597	14.00
15.00	01500	PHARMACY	-98,632	5,247,509	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,686,293	3,128,788	16.00
17.00	01700	SOCIAL SERVICE	0	2,173,494	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	483,306	483,306	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	642,269	642,269	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	840,961	40,135,589	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,161,786	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-427,408	8,503,377	35.00
40.00	04000	SUBPROVIDER - I PF	-261,326	2,311,900	40.00
43.00	04300	NURSERY	0	2,221,741	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,074,938	50.00
51.00	05100	RECOVERY ROOM	0	3,434,427	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,399,940	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-55,431	4,143,321	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	934,079	55.00
57.00	05700	CT SCAN	0	1,509,678	57.00
58.00	05800	MRI	-11,627	890,907	58.00
59.00	05900	CARDIAC CATHETERIZATION	200,458	200,590	59.00
60.00	06000	LABORATORY	-1,276,169	9,577,269	60.00
64.00	06400	INTRAVENOUS THERAPY	0	848,338	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,052,066	65.00
66.00	06600	PHYSICAL THERAPY	-1,686	6,662,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,883,020	67.00
68.00	06800	SPEECH PATHOLOGY	0	322,226	68.00
69.00	06900	ELECTROCARDIOLOGY	-179,618	605,382	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	224,277	1,815,626	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,558,640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,538,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	476,293	17,262,570	73.00
73.01	07301	SPECIALTY PHARMACY	397,221	17,742,140	73.01
74.00	07400	RENAL DIALYSIS	0	1,386,181	74.00
76.00	03330	ENDOSCOPY	0	1,995,897	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
76.04	03953	WOUND CARE	0	225,202	76.04
76.06	03954	IMAGING CENTER	0	3,523,390	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	9,447,294	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	INFUSION CENTER	0	218,915	90.01
90.26	04975	SPINE CENTER	0	256,362	90.26
91.00	09100	EMERGENCY	871,200	9,940,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-62,569,391	349,766,496	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	95,996	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	PAVILLIONS	0	25,826	194.06
194.08	07958	OTHER NRCC	0	1,366,885	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-62,569,391	351,255,203	200.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:
6/30/2020 2:16 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - Chargeable Medical Supplies					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	20,558,640	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	TOTALS		0	20,558,640	
B - Implantable Device Recl ass					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		14,538,159	1.00
2.00					2.00
3.00					3.00
			0	14,538,159	
C - Drugs Charges to Pat					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,786,277	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	16,786,277	
D - Depreciation Expense					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,824,925	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
TOTALS			0	14,824,925		
E - Interest Expense						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,426,889		1.00
TOTALS			0	13,426,889		
F - Other Capital Rental						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,231,784		1.00
2.00	PAVILLIONS	194.06	0	6,348		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
TOTALS			0	4,238,132		
G - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,666		1.00
2.00	OPERATION OF PLANT	7.00	0	22,842		2.00
3.00	HOUSEKEEPING	9.00	0	24,885		3.00
4.00	DIETARY	10.00	0	15,575		4.00
5.00	NURSING ADMINISTRATION	13.00	0	9,217		5.00
6.00	PHARMACY	15.00	0	19,610		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,963		7.00
8.00	SOCIAL SERVICE	17.00	0	9,015		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	182,767		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	21,893		10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	41,238		11.00
12.00	SUBPROVIDER - IPF	40.00	0	13,514		12.00
13.00	OPERATING ROOM	50.00	0	44,186		13.00
14.00	RECOVERY ROOM	51.00	0	2,145		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,648		15.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:
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Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	6,475		16.00
17.00	CT SCAN	57.00	0	9,532		17.00
18.00	INTRAVENOUS THERAPY	64.00	0	383		18.00
19.00	RESPIRATORY THERAPY	65.00	0	28,742		19.00
20.00	PHYSICAL THERAPY	66.00	0	24,737		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,817		21.00
22.00	ENDOSCOPY	76.00	0	10,583		22.00
23.00	WOUND CARE	76.04	0	5,239		23.00
24.00	IMAGING CENTER	76.06	0	7,942		24.00
25.00	EMERGENCY	91.00	0	39,719		25.00
26.00	OTHER NRCC	194.08	0	1,196		26.00
	TOTALS		0	586,529		
H - Labor and Delivery						
1.00	NURSERY	43.00	1,536,696	685,045		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4,239,401	1,889,887		2.00
	TOTALS		5,776,097	2,574,932		
I - Cafeteria						
1.00	CAFETERIA	11.00	1,893,968	2,133,844		1.00
	TOTALS		1,893,968	2,133,844		
J - Therapy						
1.00	OCCUPATIONAL THERAPY	67.00	1,287,705	595,315		1.00
2.00	SPEECH PATHOLOGY	68.00	220,355	101,871		2.00
	TOTALS		1,508,060	697,186		
K - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,688,029		1.00
	TOTALS		0	8,688,029		
L - Capital Insurance Costs						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	205,390		1.00
	TOTALS		0	205,390		
M - Radiology Support						
1.00	RADIOLOGY-THERAPEUTIC	55.00	112,779	43,723		1.00
2.00	CT SCAN	57.00	208,692	80,907		2.00
3.00	MRI	58.00	53,373	20,692		3.00
	TOTALS		374,844	145,322		
N - Specialty Pharmacy						
1.00	SPECIALTY PHARMACY	73.01	1,876,658	7,851,573		1.00
	TOTALS		1,876,658	7,851,573		
500.00	Grand Total: Increases		11,429,627	107,255,827		500.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
Date/Time Prepared:
6/30/2020 2:16 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - Chargeable Medical Supplies							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	64	0		1.00
2.00	OPERATION OF PLANT	7.00	0	67,206	0		2.00
3.00	DIETARY	10.00	0	2,187	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	230	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	515,941	0		5.00
6.00	PHARMACY	15.00	0	347,787	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2,198,252	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	454,153	0		8.00
9.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	275,516	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	4,940	0		10.00
11.00	OPERATING ROOM	50.00	0	12,108,862	0		11.00
12.00	RECOVERY ROOM	51.00	0	268,722	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	378,633	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,290,299	0		14.00
15.00	CT SCAN	57.00	0	239,682	0		15.00
16.00	MRI	58.00	0	17,040	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	276	0		17.00
18.00	LABORATORY	60.00	0	31	0		18.00
19.00	INTRAVENOUS THERAPY	64.00	0	83,974	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	468,668	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	48,138	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	212	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	78,045	0		23.00
24.00	RENAL DIALYSIS	74.00	0	1,859	0		24.00
25.00	ENDOSCOPY	76.00	0	1,198,616	0		25.00
26.00	WOUND CARE	76.04	0	18,238	0		26.00
27.00	IMAGING CENTER	76.06	0	106,252	0		27.00
28.00	INFUSION CENTER	90.01	0	8,782	0		28.00
29.00	EMERGENCY	91.00	0	374,821	0		29.00
30.00	PAVILLIONS	194.06	0	32	0		30.00
31.00	OTHER NRCC	194.08	0	1,182	0		31.00
	TOTALS		0	20,558,640			
B - Implantable Device Reclass							
1.00	OPERATING ROOM	50.00		13,116,939			1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00		1,136,303			2.00
3.00	ENDOSCOPY	76.00		284,917			3.00
			0	14,538,159			
C - Drugs Charges to Pat							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	271	0		1.00
2.00	PHARMACY	15.00	0	13,095,378	0		2.00
3.00	SOCIAL SERVICE	17.00	0	442	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	80,345	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	21,950	0		5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	2,063	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	185	0		7.00
8.00	OPERATING ROOM	50.00	0	131,892	0		8.00
9.00	RECOVERY ROOM	51.00	0	3,059	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	106,060	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	15,824	0		11.00
12.00	CT SCAN	57.00	0	151,736	0		12.00
13.00	MRI	58.00	0	89,868	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	1,118	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	4,228	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	5,751	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,454	0		17.00
18.00	ENDOSCOPY	76.00	0	3,931	0		18.00
19.00	WOUND CARE	76.04	0	16	0		19.00
20.00	IMAGING CENTER	76.06	0	146,859	0		20.00
21.00	INFUSION CENTER	90.01	0	2,900,007	0		21.00
22.00	EMERGENCY	91.00	0	23,705	0		22.00
23.00	OTHER NRCC	194.08	0	135	0		23.00
	TOTALS		0	16,786,277			
D - Depreciation Expense							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,514	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,140,961	0		2.00
3.00	OPERATION OF PLANT	7.00	0	114,361	0		3.00
4.00	HOUSEKEEPING	9.00	0	6,922	0		4.00
5.00	DIETARY	10.00	0	86,358	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	9,659	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	76,595	0		7.00
8.00	PHARMACY	15.00	0	65,881	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,520,706	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	343,111	0		10.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
Date/Time Prepared:
6/30/2020 2:16 pm

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	176,083	0		11.00	
12.00	SUBPROVIDER - IPF	40.00	0	17,318	0		12.00	
13.00	OPERATING ROOM	50.00	0	1,219,704	0		13.00	
14.00	RECOVERY ROOM	51.00	0	10,648	0		14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	400,412	0		15.00	
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	578,937	0		16.00	
17.00	CT SCAN	57.00	0	229,798	0		17.00	
18.00	MRI	58.00	0	383,146	0		18.00	
19.00	CARDIAC CATHETERIZATION	59.00	0	1,527	0		19.00	
20.00	INTRAVENOUS THERAPY	64.00	0	2,856	0		20.00	
21.00	RESPIRATORY THERAPY	65.00	0	62,309	0		21.00	
22.00	PHYSICAL THERAPY	66.00	0	265,127	0		22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	3,377	0		23.00	
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	59,823	0		24.00	
25.00	ENDOSCOPY	76.00	0	364,320	0		25.00	
26.00	WOUND CARE	76.04	0	344	0		26.00	
27.00	IMAGING CENTER	76.06	0	423,343	0		27.00	
28.00	BREAST DIAGNOSTIC CENTER	76.07	0	14,086	0		28.00	
29.00	INFUSION CENTER	90.01	0	23,996	0		29.00	
30.00	EMERGENCY	91.00	0	202,442	0		30.00	
31.00	PAVILIONS	194.06	0	19,261	0		31.00	
	TOTALS		0	14,824,925				
E - Interest Expense								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,426,889	11		1.00	
	TOTALS		0	13,426,889				
F - Other Capital Rental								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	111,622	10		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	92,017	0		2.00	
3.00	OPERATION OF PLANT	7.00	0	5,794	0		3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	80	0		4.00	
5.00	HOUSEKEEPING	9.00	0	17,518	0		5.00	
6.00	DIETARY	10.00	0	952	0		6.00	
7.00	NURSING ADMINISTRATION	13.00	0	2,509	0		7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,032,434	0		8.00	
9.00	PHARMACY	15.00	0	543,716	0		9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	80	0		10.00	
11.00	SOCIAL SERVICE	17.00	0	36	0		11.00	
12.00	ADULTS & PEDIATRICS	30.00	0	16,572	0		12.00	
13.00	INTENSIVE CARE UNIT	31.00	0	489	0		13.00	
14.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	3,403	0		14.00	
15.00	SUBPROVIDER - IPF	40.00	0	405	0		15.00	
16.00	OPERATING ROOM	50.00	0	986,059	0		16.00	
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,000	0		17.00	
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	672	0		18.00	
19.00	MRI	58.00	0	500	0		19.00	
20.00	INTRAVENOUS THERAPY	64.00	0	211	0		20.00	
21.00	RESPIRATORY THERAPY	65.00	0	69,432	0		21.00	
22.00	PHYSICAL THERAPY	66.00	0	281,322	0		22.00	
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	50,909	0		23.00	
24.00	ENDOSCOPY	76.00	0	10,355	0		24.00	
25.00	IMAGING CENTER	76.06	0	361	0		25.00	
26.00	INFUSION CENTER	90.01	0	8,800	0		26.00	
27.00	SPINE CENTER	90.26	0	482	0		27.00	
28.00	EMERGENCY	91.00	0	41	0		28.00	
29.00	OTHER NRCC	194.08	0	361	0		29.00	
	TOTALS		0	4,238,132				
G - STD BENEFIT								
1.00	ADMINISTRATIVE & GENERAL	5.00	16,666	0	0		1.00	
2.00	OPERATION OF PLANT	7.00	22,842	0	0		2.00	
3.00	HOUSEKEEPING	9.00	24,885	0	0		3.00	
4.00	DIETARY	10.00	15,575	0	0		4.00	
5.00	NURSING ADMINISTRATION	13.00	9,217	0	0		5.00	
6.00	PHARMACY	15.00	19,610	0	0		6.00	
7.00	MEDICAL RECORDS & LIBRARY	16.00	7,963	0	0		7.00	
8.00	SOCIAL SERVICE	17.00	9,015	0	0		8.00	
9.00	ADULTS & PEDIATRICS	30.00	182,767	0	0		9.00	
10.00	INTENSIVE CARE UNIT	31.00	21,893	0	0		10.00	
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	41,238	0	0		11.00	
12.00	SUBPROVIDER - IPF	40.00	13,514	0	0		12.00	
13.00	OPERATING ROOM	50.00	44,186	0	0		13.00	
14.00	RECOVERY ROOM	51.00	2,145	0	0		14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	16,648	0	0		15.00	
16.00	RADIOLOGY-THERAPEUTIC	55.00	6,475	0	0		16.00	
17.00	CT SCAN	57.00	9,532	0	0		17.00	

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.		
	6.00	7.00	8.00	9.00	10.00			
18.00	INTRAVENOUS THERAPY	64.00	383	0	0	0		18.00
19.00	RESPIRATORY THERAPY	65.00	28,742	0	0	0		19.00
20.00	PHYSICAL THERAPY	66.00	24,737	0	0	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	3,817	0	0	0		21.00
22.00	ENDOSCOPY	76.00	10,583	0	0	0		22.00
23.00	WOUND CARE	76.04	5,239	0	0	0		23.00
24.00	IMAGING CENTER	76.06	7,942	0	0	0		24.00
25.00	EMERGENCY	91.00	39,719	0	0	0		25.00
26.00	OTHER NRCC	194.08	1,196	0	0	0		26.00
	TOTALS		586,529	0				
H - Labor and Delivery								
1.00	ADULTS & PEDIATRICS	30.00	5,776,097	2,574,932	0	0		1.00
2.00		0.00	0	0	0	0		2.00
	TOTALS		5,776,097	2,574,932				
I - Cafeteria								
1.00	DIETARY	10.00	1,893,968	2,133,844	0	0		1.00
	TOTALS		1,893,968	2,133,844				
J - Therapy								
1.00	PHYSICAL THERAPY	66.00	1,508,060	697,186	0	0		1.00
2.00		0.00	0	0	0	0		2.00
	TOTALS		1,508,060	697,186				
K - BUILDING DEPRECIATION								
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,688,029	9	9		1.00
	TOTALS		0	8,688,029				
L - Capital Insurance Costs								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	205,390	12	12		1.00
	TOTALS		0	205,390				
M - Radiology Support								
1.00	RADIOLOGY-DIAGNOSTIC	54.00	374,844	145,322	0	0		1.00
2.00		0.00	0	0	0	0		2.00
3.00		0.00	0	0	0	0		3.00
	TOTALS		374,844	145,322				
N - Specialty Pharmacy								
1.00	PHARMACY	15.00	1,876,658	7,851,573	0	0		1.00
	TOTALS		1,876,658	7,851,573				
500.00	Grand Total: Decreases		12,016,156	106,669,298				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7
Part I
Date/Time Prepared:
6/30/2020 2:16 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,705,851	0	0	0	0	1.00
2.00	Land Improvements	3,747,533	611,299	0	611,299	0	2.00
3.00	Buildings and Fixtures	320,765,033	18,737,018	0	18,737,018	15,920,183	3.00
4.00	Building Improvements	2,597,127	622,401	0	622,401	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	111,616,189	8,774,121	0	8,774,121	30,164	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	441,431,733	28,744,839	0	28,744,839	15,950,347	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	441,431,733	28,744,839	0	28,744,839	15,950,347	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,705,851	0				1.00
2.00	Land Improvements	4,358,832	0				2.00
3.00	Buildings and Fixtures	323,581,868	0				3.00
4.00	Building Improvements	3,219,528	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	120,360,146	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	454,226,225	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	454,226,225	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7
Part II
Date/Time Prepared:
6/30/2020 2:16 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7
Part III
Date/Time Prepared:
6/30/2020 2:16 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	329,815,544	0	329,815,544	0.747150	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	111,616,189	0	111,616,189	0.252850	0	2.00
3.00	Total (sum of lines 1-2)	441,431,733	0	441,431,733	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	8,688,029	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,769,904	4,231,784	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,457,933	4,231,784	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	5,708,026	205,390	0	0	14,601,445	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	16,001,688	2.00
3.00	Total (sum of lines 1-2)	5,708,026	205,390	0	0	30,603,133	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0169

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

Worksheet A-8

Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	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)	B	-16,705		ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-776,673					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	1,916,367					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-2,652,289		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts			0		0.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)				UTILIZATION REVIEW-SNF	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)				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: 15-0169

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

Worksheet A-8

Date/Time Prepared:
6/30/2020 2:16 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
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
33.01 Misc Revenue	B	-136,810	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.01
33.02 Misc Revenue	B	-920	ADMINISTRATIVE & GENERAL	5.00		0	33.02
33.03 Misc Revenue	B	-29,725	OPERATION OF PLANT	7.00		0	33.03
33.04 Misc Revenue	B	-20,163	DIETARY	10.00		0	33.04
33.05 Misc Revenue	B	-98,632	PHARMACY	15.00		0	33.05
33.06 Misc Revenue	B	-90	ADULTS & PEDIATRICS	30.00		0	33.06
33.07 Misc Revenue	B	-1,520	NEONATAL INTENSIVE CARE UNIT	35.00		0	33.07
33.08 Misc Revenue	B	-111,063	RADIOLOGY-DIAGNOSTIC	54.00		0	33.08
33.09 Misc Revenue	B	-11,627	MRI	58.00		0	33.09
33.10 Misc Revenue	B	-291	LABORATORY	60.00		0	33.10
33.11 Misc Revenue	B	-1,216	PHYSICAL THERAPY	66.00		0	33.11
34.01 00 Non-Allow Interest Expense	A	-4,149,875	CAP REL COSTS-BLDG & FIXT	1.00		11	34.01
34.02 LOC Non-Allow Interest Expense	A	-88,397	CAP REL COSTS-BLDG & FIXT	1.00		11	34.02
34.03 12A Non-Allow Interest Expense	A	-2,224,425	CAP REL COSTS-BLDG & FIXT	1.00		11	34.03
34.04 12B Non-Allow Interest Expense	A	-232,079	CAP REL COSTS-BLDG & FIXT	1.00		11	34.04
34.05 50M BMO Non-Allow Interest Expense	A	-77,368	CAP REL COSTS-BLDG & FIXT	1.00		11	34.05
34.06 16AB Non-Allow Interest Expense	A	-946,719	CAP REL COSTS-BLDG & FIXT	1.00		11	34.06
34.07 Non-Allow Debt Issuance Expense	A	76,650	ADMINISTRATIVE & GENERAL	5.00		0	34.07
34.10 HAF Tax Offset	A	-27,812,505	ADMINISTRATIVE & GENERAL	5.00		0	34.10
35.00 Bad Debt	A	-23,329,999	ADMINISTRATIVE & GENERAL	5.00		0	35.00
35.01 Space Rental Income	B	-59,019	ADMINISTRATIVE & GENERAL	5.00		0	35.01
35.02 Space Rental Income	B	-20,400	OPERATION OF PLANT	7.00		0	35.02
35.03 Investment Income	B	-1,275,878	LABORATORY	60.00		0	35.03
36.00 Meals of Wheels Cost	A	-50,101	CAFETERIA	11.00		0	36.00
36.01 Sponsorship	A	-130,249	ADMINISTRATIVE & GENERAL	5.00		0	36.01
36.02 Sponsorship	A	-470	PHYSICAL THERAPY	66.00		0	36.02
36.03 Nurse Practitioner Offset	A	-305,888	NEONATAL INTENSIVE CARE UNIT	35.00		0	36.03
36.04 CARDIAC CATH SHARED SERVICES	A	200,458	CARDIAC CATHETERIZATION	59.00		0	36.04
36.05 CARDIAC MONITORING SHARED SERVICES	A	-201,770	ELECTROCARDIOLOGY	69.00		0	36.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-62,569,391					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: 15-0169

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

Worksheet A-8-1

Date/Time Prepared: 6/30/2020 2:16 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	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	483,306	0
2.00	22.00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	642,269	0
3.00	5.00	ADMINISTRATIVE & GENERAL	7250 CLEARVISTA	229,551	245,891
3.01	70.00	ELECTROENCEPHALOGRAPHY	7250 CLEARVISTA	98,744	135,185
3.02	73.01	SPECIALTY PHARMACY	7250 CLEARVISTA	452,520	55,299
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5,633,008	0
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	4,734,250	0
4.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	53,401,544	0
4.03	7.00	OPERATION OF PLANT	HOME OFFICE	650,266	0
4.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	5,065,167	0
4.05	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	1,449,201	0
4.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	2,686,293	0
4.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	840,998	0
4.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	55,632	0
4.09	69.00	ELECTROCARDIOLOGY	HOME OFFICE	22,152	0
4.10	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	260,718	0
4.11	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	476,293	0
4.12	30.00	ADULTS & PEDIATRICS	HOME OFFICE	53	0
4.13	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	0	75,715,543
4.14	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	15,120	0
4.15	91.00	EMERGENCY	CPN CALL	871,200	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			78,068,285	76,151,918

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

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

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

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

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

6.00	B	CHNW	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: 15-0169

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

Worksheet A-8-1

Date/Time Prepared:
6/30/2020 2:16 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	483,306	0		1.00
2.00	642,269	0		2.00
3.00	-16,340	0		3.00
3.01	-36,441	0		3.01
3.02	397,221	0		3.02
4.00	5,633,008	9		4.00
4.01	4,734,250	0		4.01
4.02	53,401,544	0		4.02
4.03	650,266	0		4.03
4.04	5,065,167	0		4.04
4.05	1,449,201	0		4.05
4.06	2,686,293	0		4.06
4.07	840,998	0		4.07
4.08	55,632	0		4.08
4.09	22,152	0		4.09
4.10	260,718	0		4.10
4.11	476,293	0		4.11
4.12	53	0		4.12
4.13	-75,715,543	0		4.13
4.14	15,120	0		4.14
4.15	871,200	0		4.15
5.00	1,916,367			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			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: 15-0169

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

Worksheet A-8-2

Date/Time Prepared:
6/30/2020 2:16 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	606,847	228,388	378,459	211,500	2,080	1.00
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	120,000	120,000	0	0	0	2.00
3.00	40.00	AGGREGATE-SUBPROVIDER - IPF	261,326	261,326	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			988,173	609,714	378,459		2,080	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	211,500	10,575	0	0	0	1.00
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0	2.00
3.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			211,500	10,575	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	211,500	166,959	395,347	1.00
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	120,000	2.00
3.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	261,326	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	211,500	166,959	776,673	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	14,601,445	14,601,445			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	16,001,688		16,001,688		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,925,218	6,214	112,175	5,043,607	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	62,822,718	429,895	6,452,432	262,961	5.00
7.00 00700	OPERATION OF PLANT	11,442,234	1,858,178	88,678	148,752	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	984,258	52,347	79	0	8.00
9.00 00900	HOUSEKEEPING	4,895,168	132,252	24,232	142,050	9.00
10.00 01000	DIETARY	1,361,753	117,470	16,291	29,850	10.00
11.00 01100	CAFETERIA	1,325,422	342,403	63,752	89,138	11.00
13.00 01300	NURSING ADMINISTRATION	8,068,830	23,655	12,065	110,133	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	878,597	335,928	2,090,613	0	14.00
15.00 01500	PHARMACY	5,247,509	163,625	601,365	234,564	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,128,788	5,843	79	17,407	16.00
17.00 01700	SOCIAL SERVICE	2,173,494	40,029	36	80,419	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	483,306	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	642,269	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	40,135,589	4,529,797	788,777	1,336,863	30.00
31.00 03100	INTENSIVE CARE UNIT	6,161,786	977,741	180,818	221,244	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	8,503,377	868,359	174,405	300,546	35.00
40.00 04000	SUBPROVIDER - IPF	2,311,900	156,147	17,572	89,041	40.00
43.00 04300	NURSERY	2,221,741	375,761	46,015	72,323	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,074,938	686,769	2,169,537	243,956	50.00
51.00 05100	RECOVERY ROOM	3,434,427	368,653	8,691	114,221	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,399,940	1,036,628	126,943	208,504	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,143,321	231,932	375,000	146,729	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	934,079	252,818	404,113	28,643	55.00
57.00 05700	CT SCAN	1,509,678	33,902	234,875	52,448	57.00
58.00 05800	MRI	890,907	120,915	291,026	25,352	58.00
59.00 05900	CARDIAC CATHETERIZATION	200,590	0	1,514	0	59.00
60.00 06000	LABORATORY	9,577,269	129,527	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	848,338	172,979	3,042	29,329	64.00
65.00 06500	RESPIRATORY THERAPY	4,052,066	140,123	130,621	136,668	65.00
66.00 06600	PHYSICAL THERAPY	6,662,481	22,543	477,000	223,254	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,883,020	0	55,336	60,605	67.00
68.00 06800	SPEECH PATHOLOGY	322,226	0	9,469	10,371	68.00
69.00 06900	ELECTROCARDIOLOGY	605,382	0	3,209	1,503	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,815,626	83,415	109,790	46,554	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,558,640	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	14,538,159	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	17,262,570	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	17,742,140	0	0	88,323	73.01
74.00 07400	RENAL DIALYSIS	1,386,181	2,638	0	0	74.00
76.00 03330	ENDOSCOPY	1,995,897	180,718	350,323	57,176	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	225,202	0	341	8,660	76.04
76.06 03954	IMAGING CENTER	3,523,390	0	352,263	74,835	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	9,447,294	0	13,966	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	218,915	0	32,517	4,878	90.01
90.26 04975	SPINE CENTER	256,362	0	478	9,040	90.26
91.00 09100	EMERGENCY	9,940,368	622,910	169,089	293,774	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	349,766,496	14,502,114	15,988,527	5,000,114	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	85,617	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	95,996	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
6/30/2020 2:16 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	
194.06 07956 PAVILLIONS	25,826	0	12,803	0	38,629	194.06
194.08 07958 OTHER NRCC	1,366,885	13,714	358	43,493	1,424,450	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	351,255,203	14,601,445	16,001,688	5,043,607	351,255,203	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part I Date/Time Prepared: 6/30/2020 2:16 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	69,968,006					5.00
7.00	00700	OPERATION OF PLANT	3,367,430	16,905,272				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	257,867	71,905	1,366,456			8.00
9.00	00900	HOUSEKEEPING	1,291,892	181,663	0	6,667,257		9.00
10.00	01000	DIETARY	379,422	161,359	0	64,607	2,130,752	10.00
11.00	01100	CAFETERIA	452,888	470,330	0	188,318	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,043,337	32,493	0	13,010	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	822,127	461,435	0	184,756	0	14.00
15.00	01500	PHARMACY	1,553,907	224,758	0	89,992	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	784,064	8,026	0	3,214	0	16.00
17.00	01700	SOCIAL SERVICE	570,609	54,984	0	22,015	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	120,219	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	159,759	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,638,956	6,222,185	690,687	2,491,330	1,388,613	30.00
31.00	03100	INTENSIVE CARE UNIT	1,875,910	1,343,037	65,896	537,745	158,045	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,449,285	1,192,789	51,422	477,587	281,481	35.00
40.00	04000	SUBPROVIDER - I PF	640,426	214,486	15,899	85,879	124,185	40.00
43.00	04300	NURSERY	675,543	516,150	33,299	206,664	178,428	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,525,968	943,355	52,135	377,714	0	50.00
51.00	05100	RECOVERY ROOM	976,559	506,387	0	202,755	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,933,227	1,423,926	91,864	570,133	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,218,085	318,584	72,265	127,560	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	402,876	347,274	10,889	139,047	0	55.00
57.00	05700	CT SCAN	455,422	46,569	0	18,646	0	57.00
58.00	05800	MRI	330,379	166,090	0	66,502	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	50,272	0	0	0	0	59.00
60.00	06000	LABORATORY	2,414,488	177,920	0	71,238	0	60.00
64.00	06400	INTRAVENOUS THERAPY	262,096	237,606	0	95,136	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,109,259	192,474	0	77,066	0	65.00
66.00	06600	PHYSICAL THERAPY	1,837,029	30,966	0	12,399	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	497,226	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	85,086	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	151,756	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	511,261	114,580	0	45,877	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,113,797	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,616,251	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,293,926	0	0	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	4,435,185	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	345,458	3,624	0	1,451	0	74.00
76.00	03330	ENDOSCOPY	642,778	248,237	30,868	99,393	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	58,256	0	0	0	0	76.04
76.06	03954	IMAGING CENTER	982,652	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	2,353,413	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	63,755	0	0	0	0	90.01
90.26	04975	SPINE CENTER	66,136	0	0	0	0	90.26
91.00	09100	EMERGENCY	2,742,664	855,638	251,232	342,593	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,558,901	16,768,830	1,366,456	6,612,627	2,130,752	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,297	117,605	0	47,088	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,878	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	9,609	0	0	0	0	194.06
194.08	07958	OTHER NRCC	354,321	18,837	0	7,542	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0169			Period: From 01/01/2019 To 12/31/2019		Worksheet B Part I Date/Time Prepared: 6/30/2020 2:16 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
202.00	TOTAL (sum lines 118 through 201)	69,968,006	16,905,272	1,366,456	6,667,257	2,130,752	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,932,251					11.00
13.00	01300	79,183	10,382,706				13.00
14.00	01400	0	0	4,773,456			14.00
15.00	01500	197,958	0	26,259	8,339,937		15.00
16.00	01600	9,898	0	1	0	3,957,320	16.00
17.00	01700	51,964	0	51	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,012,060	5,097,871	224,773	0	475,815	30.00
31.00	03100	165,790	835,104	40,446	0	69,235	31.00
35.00	02060	202,907	1,022,067	43,240	0	225,959	35.00
40.00	04000	66,811	336,534	7,318	0	29,723	40.00
43.00	04300	54,438	274,213	11,400	0	24,491	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	178,162	897,425	270,183	0	527,221	50.00
51.00	05100	79,183	0	34,576	0	90,141	51.00
52.00	05200	148,468	747,854	31,450	0	67,566	52.00
54.00	05400	96,504	0	14,349	0	106,841	54.00
55.00	05500	19,796	0	17,584	0	93,520	55.00
57.00	05700	34,643	0	1,077	0	194,755	57.00
58.00	05800	14,847	0	160	0	51,125	58.00
59.00	05900	0	0	7	0	11,422	59.00
60.00	06000	0	0	148,713	0	328,711	60.00
64.00	06400	19,796	0	2,509	0	6,872	64.00
65.00	06500	94,030	0	24,064	0	71,866	65.00
66.00	06600	37,117	0	13,889	0	75,025	66.00
67.00	06700	37,117	0	3,583	0	22,402	67.00
68.00	06800	7,423	0	613	0	5,651	68.00
69.00	06900	2,474	0	38	0	30,900	69.00
70.00	07000	37,117	0	13,215	0	34,920	70.00
71.00	07100	0	0	2,064,709	0	196,799	71.00
72.00	07200	0	0	1,460,082	0	116,749	72.00
73.00	07300	0	0	0	8,339,937	315,826	73.00
73.01	07301	0	0	176,349	0	51,047	73.01
74.00	07400	0	0	159	0	10,700	74.00
76.00	03330	42,066	0	22,675	0	64,798	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03951	0	0	0	0	0	76.02
76.03	03952	0	0	0	0	0	76.03
76.04	03953	4,949	0	1,688	0	2,926	76.04
76.06	03954	0	0	18,593	0	152,623	76.06
76.07	03955	0	0	504	0	63,316	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	04950	4,949	0	1,483	0	1,581	90.01
90.26	04975	0	0	464	0	1,617	90.26
91.00	09100	232,601	1,171,638	93,526	0	435,177	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00	11800	2,932,251	10,382,706	4,769,730	8,339,937	3,957,320	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	2,965	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	478	0	0	194.06
194.08	07958	0	0	283	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,932,251	10,382,706	4,773,456	8,339,937	3,957,320	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			17.00	19.00		
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500						15.00
16.00 01600						16.00
17.00 01700	2,993,601					17.00
19.00 01900		0				19.00
21.00 02100			603,525			21.00
22.00 02200				802,028		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	1,950,934	0	367,893	488,895	78,841,038	30.00
31.00 03100	222,045	0	0	0	12,854,842	31.00
35.00 02060	395,466	0	0	0	16,188,890	35.00
40.00 04000	174,473	0	171,898	228,437	4,670,729	40.00
43.00 04300	250,683	0	0	0	4,941,149	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0	0	0	0	20,947,363	50.00
51.00 05100	0	0	0	0	5,815,593	51.00
52.00 05200	0	0	0	0	12,786,503	52.00
54.00 05400	0	0	0	0	6,851,170	54.00
55.00 05500	0	0	0	0	2,650,639	55.00
57.00 05700	0	0	0	0	2,582,015	57.00
58.00 05800	0	0	0	0	1,957,303	58.00
59.00 05900	0	0	0	0	263,805	59.00
60.00 06000	0	0	0	0	12,847,866	60.00
64.00 06400	0	0	0	0	1,677,703	64.00
65.00 06500	0	0	0	0	6,028,237	65.00
66.00 06600	0	0	12,244	16,271	9,420,218	66.00
67.00 06700	0	0	0	0	2,559,289	67.00
68.00 06800	0	0	0	0	440,839	68.00
69.00 06900	0	0	0	0	795,262	69.00
70.00 07000	0	0	0	0	2,812,355	70.00
71.00 07100	0	0	0	0	27,933,945	71.00
72.00 07200	0	0	0	0	19,731,241	72.00
73.00 07300	0	0	0	0	30,212,259	73.00
73.01 07301	0	0	0	0	22,493,044	73.01
74.00 07400	0	0	0	0	1,750,211	74.00
76.00 03330	0	0	0	0	3,734,929	76.00
76.01 03950	0	0	0	0	0	76.01
76.02 03951	0	0	0	0	0	76.02
76.03 03952	0	0	0	0	0	76.03
76.04 03953	0	0	0	0	302,022	76.04
76.06 03954	0	0	0	0	5,104,356	76.06
76.07 03955	0	0	0	0	11,878,493	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	0	0	0	0	0	90.00
90.01 04950	0	0	0	0	328,078	90.01
90.26 04975	0	0	0	0	334,097	90.26
91.00 09100	0	0	51,490	68,425	17,271,125	91.00
92.00 09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300						113.00
114.00 11400						114.00
118.00	2,993,601	0	603,525	802,028	349,006,608	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	0	0	0	0	271,607	190.00
191.00 19100	0	0	0	0	0	191.00
192.00 19200	0	0	0	0	122,839	192.00
193.00 19300	0	0	0	0	0	193.00
194.00 07950	0	0	0	0	0	194.00
194.06 07956	0	0	0	0	48,716	194.06
194.08 07958	0	0	0	0	1,805,433	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
					17.00	19.00		
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments		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)	2,993,601	0	603,525	802,028	351,255,203	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-856,788	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
40.00	04000	SUBPROVIDER - I PF	-400,335	40.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	-28,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	73.01
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03330	ENDOSCOPY	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	76.03
76.04	03953	WOUND CARE	0	76.04
76.06	03954	IMAGING CENTER	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	04950	INFUSION CENTER	0	90.01
90.26	04975	SPINE CENTER	0	90.26
91.00	09100	EMERGENCY	-119,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,405,553	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	HOME OFFICE	0	194.00
194.06	07956	PAVILLIONS	0	194.06
194.08	07958	OTHER NRCC	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
194.10	07960 COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	-1,405,553	349,849,650	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	6,214	112,175	118,389	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	429,895	6,452,432	6,882,327	5.00
7.00 00700	OPERATION OF PLANT	0	1,858,178	88,678	1,946,856	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	52,347	79	52,426	8.00
9.00 00900	HOUSEKEEPING	0	132,252	24,232	156,484	9.00
10.00 01000	DIETARY	0	117,470	16,291	133,761	10.00
11.00 01100	CAFETERIA	0	342,403	63,752	406,155	11.00
13.00 01300	NURSING ADMINISTRATION	0	23,655	12,065	35,720	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	335,928	2,090,613	2,426,541	14.00
15.00 01500	PHARMACY	0	163,625	601,365	764,990	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	5,843	79	5,922	16.00
17.00 01700	SOCIAL SERVICE	0	40,029	36	40,065	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	4,529,797	788,777	5,318,574	30.00
31.00 03100	INTENSIVE CARE UNIT	0	977,741	180,818	1,158,559	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	868,359	174,405	1,042,764	35.00
40.00 04000	SUBPROVIDER - I PF	0	156,147	17,572	173,719	40.00
43.00 04300	NURSERY	0	375,761	46,015	421,776	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	686,769	2,169,537	2,856,306	50.00
51.00 05100	RECOVERY ROOM	0	368,653	8,691	377,344	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	1,036,628	126,943	1,163,571	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	231,932	375,000	606,932	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	252,818	404,113	656,931	55.00
57.00 05700	CT SCAN	0	33,902	234,875	268,777	57.00
58.00 05800	MRI	0	120,915	291,026	411,941	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	1,514	1,514	59.00
60.00 06000	LABORATORY	0	129,527	0	129,527	60.00
64.00 06400	INTRAVENOUS THERAPY	0	172,979	3,042	176,021	64.00
65.00 06500	RESPIRATORY THERAPY	0	140,123	130,621	270,744	65.00
66.00 06600	PHYSICAL THERAPY	0	22,543	477,000	499,543	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	55,336	55,336	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	9,469	9,469	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	3,209	3,209	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	83,415	109,790	193,205	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
73.01 07301	SPECIALTY PHARMACY	0	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	0	2,638	0	2,638	74.00
76.00 03330	ENDOSCOPY	0	180,718	350,323	531,041	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	0	0	341	341	76.04
76.06 03954	IMAGING CENTER	0	0	352,263	352,263	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	13,966	13,966	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	0	32,517	32,517	90.01
90.26 04975	SPINE CENTER	0	0	478	478	90.26
91.00 09100	EMERGENCY	0	622,910	169,089	791,999	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	0	14,502,114	15,988,527	30,490,641	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	85,617	0	85,617	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	PAVILLIONS	0	0	12,803	12,803	194.06

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 6/30/2020 2:16 pm	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		1.00	2.00					
	0	1.00	2.00	2A	4.00			
194.08 07958 OTHER NRCC	0	13,714	358	14,072	1,021	194.08		
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10		
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)	0	14,601,445	16,001,688	30,603,133	118,389	202.00		

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 6/30/2020 2:16 pm		
Cost Center Description				ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
				5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,888,501					5.00
7.00	00700	OPERATION OF PLANT	331,528	2,281,876				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,387	9,706	87,519			8.00
9.00	00900	HOUSEKEEPING	127,189	24,521	0	311,529		9.00
10.00	01000	DIETARY	37,355	21,780	0	3,019	196,616	10.00
11.00	01100	CAFETERIA	44,587	63,485	0	8,799	0	11.00
13.00	01300	NURSING ADMINISTRATION	201,169	4,386	0	608	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,940	62,285	0	8,633	0	14.00
15.00	01500	PHARMACY	152,984	30,338	0	4,205	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,192	1,083	0	150	0	16.00
17.00	01700	SOCIAL SERVICE	56,177	7,422	0	1,029	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	11,836	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	15,729	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,145,923	839,871	44,238	116,408	128,134	30.00
31.00	03100	INTENSIVE CARE UNIT	184,686	181,283	4,220	25,126	14,584	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	241,136	161,003	3,294	22,315	25,974	35.00
40.00	04000	SUBPROVIDER - I/PF	63,051	28,951	1,018	4,013	11,459	40.00
43.00	04300	NURSERY	66,508	69,670	2,133	9,656	16,465	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	347,136	127,334	3,339	17,649	0	50.00
51.00	05100	RECOVERY ROOM	96,144	68,352	0	9,474	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	190,329	192,202	5,884	26,640	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,922	43,003	4,628	5,960	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	39,664	46,875	697	6,497	0	55.00
57.00	05700	CT SCAN	44,837	6,286	0	871	0	57.00
58.00	05800	MRI	32,526	22,419	0	3,107	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,949	0	0	0	0	59.00
60.00	06000	LABORATORY	237,710	24,016	0	3,329	0	60.00
64.00	06400	INTRAVENOUS THERAPY	25,804	32,072	0	4,445	0	64.00
65.00	06500	RESPIRATORY THERAPY	109,208	25,980	0	3,601	0	65.00
66.00	06600	PHYSICAL THERAPY	180,858	4,180	0	579	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,953	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,377	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,941	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	50,334	15,466	0	2,144	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	503,461	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	356,025	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	422,743	0	0	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	436,650	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	34,011	489	0	68	0	74.00
76.00	03330	ENDOSCOPY	63,282	33,507	1,977	4,644	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	5,735	0	0	0	0	76.04
76.06	03954	IMAGING CENTER	96,744	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	231,697	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	6,277	0	0	0	0	90.01
90.26	04975	SPINE CENTER	6,511	0	0	0	0	90.26
91.00	09100	EMERGENCY	270,019	115,494	16,091	16,008	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,848,224	2,263,459	87,519	308,977	196,616	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,097	15,874	0	2,200	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,351	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	946	0	0	0	0	194.06
194.08	07958	OTHER NRCC	34,883	2,543	0	352	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169			Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 6/30/2020 2:16 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
202.00	TOTAL (sum lines 118 through 201)	6,888,501	2,281,876	87,519	311,529	196,616	202.00	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 6/30/2020 2:16 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	525,119					11.00
13.00	01300	NURSING ADMINISTRATION	14,180	258,649				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,578,399			14.00
15.00	01500	PHARMACY	35,451	0	14,184	1,007,659		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,773	0	1	0	86,530	16.00
17.00	01700	SOCIAL SERVICE	9,306	0	27	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	181,247	126,996	121,412	0	10,445	30.00
31.00	03100	INTENSIVE CARE UNIT	29,690	20,804	21,847	0	1,520	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	36,337	25,461	23,356	0	4,960	35.00
40.00	04000	SUBPROVIDER - I PF	11,965	8,384	3,953	0	652	40.00
43.00	04300	NURSERY	9,749	6,831	6,158	0	538	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,906	22,356	145,940	0	11,233	50.00
51.00	05100	RECOVERY ROOM	14,180	0	18,676	0	1,979	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,588	18,630	16,988	0	1,483	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,282	0	7,751	0	2,345	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,545	0	9,498	0	2,053	55.00
57.00	05700	CT SCAN	6,204	0	582	0	4,275	57.00
58.00	05800	MRI	2,659	0	86	0	1,122	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	4	0	251	59.00
60.00	06000	LABORATORY	0	0	80,328	0	7,216	60.00
64.00	06400	INTRAVENOUS THERAPY	3,545	0	1,355	0	151	64.00
65.00	06500	RESPIRATORY THERAPY	16,839	0	12,998	0	1,578	65.00
66.00	06600	PHYSICAL THERAPY	6,647	0	7,502	0	1,647	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,647	0	1,935	0	492	67.00
68.00	06800	SPEECH PATHOLOGY	1,329	0	331	0	124	68.00
69.00	06900	ELECTROCARDIOLOGY	443	0	21	0	678	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,647	0	7,138	0	767	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,115,264	0	4,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	788,666	0	2,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,007,659	6,933	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	95,255	0	1,121	73.01
74.00	07400	RENAL DIALYSIS	0	0	86	0	235	74.00
76.00	03330	ENDOSCOPY	7,533	0	12,248	0	1,422	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	886	0	912	0	64	76.04
76.06	03954	IMAGING CENTER	0	0	10,043	0	3,350	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	272	0	1,390	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	886	0	801	0	35	90.01
90.26	04975	SPINE CENTER	0	0	251	0	35	90.26
91.00	09100	EMERGENCY	41,655	29,187	50,518	0	9,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	525,119	258,649	2,576,387	1,007,659	86,530	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,601	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	0	258	0	0	194.06
194.08	07958	OTHER NRCC	0	0	153	0	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169			Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 6/30/2020 2:16 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	525,119	258,649	2,578,399	1,007,659	86,530		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			17.00	19.00		
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500						15.00
16.00 01600						16.00
17.00 01700	115,914					17.00
19.00 01900		0				19.00
21.00 02100			11,836			21.00
22.00 02200				15,729		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	75,540				8,140,148	30.00
31.00 03100					1,656,112	31.00
35.00 02060	15,313				1,608,969	35.00
40.00 04000	6,756				316,012	40.00
43.00 04300	9,707				620,889	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0				3,568,927	50.00
51.00 05100	0				588,831	51.00
52.00 05200	0				1,647,210	52.00
54.00 05400	0				811,268	54.00
55.00 05500	0				766,433	55.00
57.00 05700	0				333,063	57.00
58.00 05800	0				474,455	58.00
59.00 05900	0				6,718	59.00
60.00 06000	0				482,126	60.00
64.00 06400	0				244,082	64.00
65.00 06500	0				444,157	65.00
66.00 06600	0				706,198	66.00
67.00 06700	0				114,786	67.00
68.00 06800	0				19,873	68.00
69.00 06900	0				19,327	69.00
70.00 07000	0				276,794	70.00
71.00 07100	0				1,623,045	71.00
72.00 07200	0				1,147,254	72.00
73.00 07300	0				1,437,335	73.00
73.01 07301	0				535,100	73.01
74.00 07400	0				37,527	74.00
76.00 03330	0				656,996	76.00
76.01 03950	0				0	76.01
76.02 03951	0				0	76.02
76.03 03952	0				0	76.03
76.04 03953	0				8,141	76.04
76.06 03954	0				464,157	76.06
76.07 03955	0				247,325	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	0				0	90.00
90.01 04950	0				40,631	90.01
90.26 04975	0				7,487	90.26
91.00 09100	0				1,347,421	91.00
92.00 09200	0				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300						113.00
114.00 11400						114.00
118.00	115,914	0	0	0	30,398,797	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	0				105,788	190.00
191.00 19100	0				0	191.00
192.00 19200	0				3,952	192.00
193.00 19300	0				0	193.00
194.00 07950	0				0	194.00
194.06 07956	0				14,007	194.06
194.08 07958	0				53,024	194.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
					17.00	19.00		
194.10	07960	COMMUNITY REHAB HOSPITAL	0				0	194.10
200.00		Cross Foot Adjustments		0	11,836	15,729	27,565	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	115,914	0	11,836	15,729	30,603,133	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
40.00	04000	SUBPROVIDER - I PF	0	40.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	73.01
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03330	ENDOSCOPY	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	76.03
76.04	03953	WOUND CARE	0	76.04
76.06	03954	IMAGING CENTER	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	04950	INFUSION CENTER	0	90.01
90.26	04975	SPINE CENTER	0	90.26
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	HOME OFFICE	0	194.00
194.06	07956	PAVILLIONS	0	194.06
194.08	07958	OTHER NRCC	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00		Cross Foot Adjustments	0	27,565	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	30,603,133	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
6/30/2020 2:16 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				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	669,724				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		16,138,846			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	285	113,137	107,163,951		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	19,718	6,507,735	5,587,313	-69,968,006	5.00
7.00 00700	OPERATION OF PLANT	85,229	89,438	3,160,627	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,401	80	0	0	8.00
9.00 00900	HOUSEKEEPING	6,066	24,440	3,018,237	0	9.00
10.00 01000	DIETARY	5,388	16,431	634,233	0	10.00
11.00 01100	CAFETERIA	15,705	64,298	1,893,968	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,085	12,168	2,340,059	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	15,408	2,108,533	0	0	14.00
15.00 01500	PHARMACY	7,505	606,520	4,983,939	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	268	80	369,868	0	16.00
17.00 01700	SOCIAL SERVICE	1,836	36	1,708,712	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	207,768	795,538	28,404,320	0	30.00
31.00 03100	INTENSIVE CARE UNIT	44,846	182,368	4,700,921	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	39,829	175,900	6,385,909	0	35.00
40.00 04000	SUBPROVIDER - IPF	7,162	17,723	1,891,911	0	40.00
43.00 04300	NURSERY	17,235	46,409	1,536,696	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	31,500	2,188,134	5,183,489	0	50.00
51.00 05100	RECOVERY ROOM	16,909	8,765	2,426,938	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	47,547	128,031	4,430,220	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,638	378,214	3,117,654	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	11,596	407,577	608,600	0	55.00
57.00 05700	CT SCAN	1,555	236,888	1,114,387	0	57.00
58.00 05800	MRI	5,546	293,521	538,676	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	1,527	0	0	59.00
60.00 06000	LABORATORY	5,941	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	7,934	3,068	623,170	0	64.00
65.00 06500	RESPIRATORY THERAPY	6,427	131,741	2,903,872	0	65.00
66.00 06600	PHYSICAL THERAPY	1,034	481,089	4,743,619	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	55,810	1,287,705	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	9,550	220,355	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	3,237	31,938	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	3,826	110,731	989,165	0	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
73.01 07301	SPECIALTY PHARMACY	0	0	1,876,658	0	73.01
74.00 07400	RENAL DIALYSIS	121	0	0	0	74.00
76.00 03330	ENDOSCOPY	8,289	353,326	1,214,866	0	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	0	344	184,007	0	76.04
76.06 03954	IMAGING CENTER	0	355,283	1,590,061	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	14,086	0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	32,796	103,638	0	90.01
90.26 04975	SPINE CENTER	0	482	192,075	0	90.26
91.00 09100	EMERGENCY	28,571	170,538	6,242,018	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	665,168	16,125,572	106,239,824	-69,968,006	279,642,505
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,927	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
6/30/2020 2:16 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				
194.06 07956 PAVILLIONS	0	12,913	0	0	38,629	194.06
194.08 07958 OTHER NRCC	629	361	924,127	0	1,424,450	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	14,601,445	16,001,688	5,043,607		69,968,006	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	21.802183	0.991501	0.047064		0.248742	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			118,389		6,888,501	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001105		0.024489	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: 15-0169

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

Worksheet B-1

Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	564,492				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,401	270,303			8.00
9.00	00900	HOUSEKEEPING	6,066	0	556,025		9.00
10.00	01000	DIETARY	5,388	0	5,388	88,226	10.00
11.00	01100	CAFETERIA	15,705	0	15,705	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,085	0	1,085	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,408	0	15,408	0	14.00
15.00	01500	PHARMACY	7,505	0	7,505	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	0	268	0	16.00
17.00	01700	SOCIAL SERVICE	1,836	0	1,836	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	207,768	136,627	207,768	57,497	30.00
31.00	03100	INTENSIVE CARE UNIT	44,846	13,035	44,846	6,544	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	39,829	10,172	39,829	11,655	35.00
40.00	04000	SUBPROVIDER - IPF	7,162	3,145	7,162	5,142	40.00
43.00	04300	NURSERY	17,235	6,587	17,235	7,388	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	31,500	10,313	31,500	0	50.00
51.00	05100	RECOVERY ROOM	16,909	0	16,909	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,547	18,172	47,547	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,638	14,295	10,638	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,596	2,154	11,596	0	55.00
57.00	05700	CT SCAN	1,555	0	1,555	0	57.00
58.00	05800	MRI	5,546	0	5,546	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	5,941	0	5,941	0	60.00
64.00	06400	INTRAVENOUS THERAPY	7,934	0	7,934	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,427	0	6,427	0	65.00
66.00	06600	PHYSICAL THERAPY	1,034	0	1,034	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,826	0	3,826	0	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
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	121	0	121	0	74.00
76.00	03330	ENDOSCOPY	8,289	6,106	8,289	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04	03953	WOUND CARE	0	0	0	0	76.04
76.06	03954	IMAGING CENTER	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	0	0	0	0	90.01
90.26	04975	SPINE CENTER	0	0	0	0	90.26
91.00	09100	EMERGENCY	28,571	49,697	28,571	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	559,936	270,303	551,469	88,226	1,185
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,927	0	3,927	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	0	0	0	194.06
194.08	07958	OTHER NRCC	629	0	629	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	194.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	16,905,272	1,366,456	6,667,257	2,130,752	2,932,251	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.947762	5.055275	11.990930	24.151067	2,474.473418	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,281,876	87,519	311,529	196,616	525,119	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.042353	0.323781	0.560279	2.228549	443.138397	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: 15-0169

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

Worksheet B-1

Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	833					13.00
14.00	01400	0	47,529,884				14.00
15.00	01500	0	261,467	16,930,108			15.00
16.00	01600	0	14	0	1,551,524,218		16.00
17.00	01700	0	504	0	0	88,226	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	409	2,238,086	0	186,521,030	57,497	30.00
31.00	03100	67	402,726	0	27,140,503	6,544	31.00
35.00	02060	82	430,549	0	88,576,583	11,655	35.00
40.00	04000	27	72,867	0	11,651,668	5,142	40.00
43.00	04300	22	113,511	0	9,600,682	7,388	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	72	2,690,235	0	206,913,833	0	50.00
51.00	05100	0	344,272	0	35,335,484	0	51.00
52.00	05200	60	313,151	0	26,486,133	0	52.00
54.00	05400	0	142,874	0	41,882,101	0	54.00
55.00	05500	0	175,086	0	36,660,309	0	55.00
57.00	05700	0	10,727	0	76,344,460	0	57.00
58.00	05800	0	1,593	0	20,041,330	0	58.00
59.00	05900	0	72	0	4,477,421	0	59.00
60.00	06000	0	1,480,748	0	128,855,828	0	60.00
64.00	06400	0	24,981	0	2,693,925	0	64.00
65.00	06500	0	239,603	0	28,171,592	0	65.00
66.00	06600	0	138,294	0	29,409,991	0	66.00
67.00	06700	0	35,672	0	8,781,809	0	67.00
68.00	06800	0	6,104	0	2,215,016	0	68.00
69.00	06900	0	379	0	12,112,876	0	69.00
70.00	07000	0	131,583	0	13,688,767	0	70.00
71.00	07100	0	20,558,641	0	77,145,878	0	71.00
72.00	07200	0	14,538,159	0	45,765,998	0	72.00
73.00	07300	0	0	16,930,108	123,804,819	0	73.00
73.01	07301	0	1,755,926	0	20,010,685	0	73.01
74.00	07400	0	1,584	0	4,194,423	0	74.00
76.00	03330	0	225,781	0	25,400,941	0	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03951	0	0	0	0	0	76.02
76.03	03952	0	0	0	0	0	76.03
76.04	03953	0	16,812	0	1,146,994	0	76.04
76.06	03954	0	185,136	0	59,828,850	0	76.06
76.07	03955	0	5,022	0	24,820,012	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	04950	0	14,769	0	619,794	0	90.01
90.26	04975	0	4,618	0	633,756	0	90.26
91.00	09100	94	931,245	0	170,590,727	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		833	47,492,791	16,930,108	1,551,524,218	88,226	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	29,521	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	4,759	0	0	0	194.06
194.08	07958	0	2,813	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	10,382,706	4,773,456	8,339,937	3,957,320	2,993,601	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12,464.232893	0.100431	0.492610	0.002551	33.931052	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	258,649	2,578,399	1,007,659	86,530	115,914	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	310.503001	0.054248	0.059519	0.000056	1.313830	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: 15-0169

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

Worksheet B-1
Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		19.00	21.00		22.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV		61,466		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			61,466	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	37,468	37,468	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	35.00
40.00 04000	SUBPROVIDER - IPF	0	17,507	17,507	40.00
43.00 04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MRI	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	1,247	1,247	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
76.00 03330	ENDOSCOPY	0	0	0	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.03
76.04 03953	WOUND CARE	0	0	0	76.04
76.06 03954	IMAGING CENTER	0	0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	0	0	90.01
90.26 04975	SPINE CENTER	0	0	0	90.26
91.00 09100	EMERGENCY	0	5,244	5,244	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
114.00 11400	UTILIZATION REVIEW-SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	61,466	61,466	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		19.00	21.00		
194.06 07956 PAVILLIONS	0	0	0		194.06
194.08 07958 OTHER NRCC	0	0	0		194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0		194.10
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	603,525	802,028		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	9.818843	13.048319		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	11,836	15,729		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.192562	0.255898		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/30/2020 2:16 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		77,984,250	0	77,984,250	30.00
31.00	03100 INTENSIVE CARE UNIT		12,854,842	0	12,854,842	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		16,188,890	0	16,188,890	35.00
40.00	04000 SUBPROVIDER - IPF		4,270,394	0	4,270,394	40.00
43.00	04300 NURSERY		4,941,149	0	4,941,149	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		20,947,363	0	20,947,363	50.00
51.00	05100 RECOVERY ROOM		5,815,593	0	5,815,593	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		12,786,503	0	12,786,503	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,851,170	0	6,851,170	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		2,650,639	0	2,650,639	55.00
57.00	05700 CT SCAN		2,582,015	0	2,582,015	57.00
58.00	05800 MRI		1,957,303	0	1,957,303	58.00
59.00	05900 CARDIAC CATHETERIZATION		263,805	0	263,805	59.00
60.00	06000 LABORATORY		12,847,866	0	12,847,866	60.00
64.00	06400 INTRAVENOUS THERAPY		1,677,703	0	1,677,703	64.00
65.00	06500 RESPIRATORY THERAPY	0	6,028,237	0	6,028,237	65.00
66.00	06600 PHYSICAL THERAPY	0	9,391,703	0	9,391,703	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,559,289	0	2,559,289	67.00
68.00	06800 SPEECH PATHOLOGY	0	440,839	0	440,839	68.00
69.00	06900 ELECTROCARDIOLOGY		795,262	0	795,262	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		2,812,355	0	2,812,355	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		27,933,945	0	27,933,945	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		19,731,241	0	19,731,241	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		30,212,259	0	30,212,259	73.00
73.01	07301 SPECIALTY PHARMACY		22,493,044	0	22,493,044	73.01
74.00	07400 RENAL DIALYSIS		1,750,211	0	1,750,211	74.00
76.00	03330 ENDOSCOPY		3,734,929	0	3,734,929	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.03
76.04	03953 WOUND CARE		302,022	0	302,022	76.04
76.06	03954 IMAGING CENTER		5,104,356	0	5,104,356	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER		11,878,493	0	11,878,493	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.01	04950 INFUSION CENTER		328,078	0	328,078	90.01
90.26	04975 SPINE CENTER		334,097	0	334,097	90.26
91.00	09100 EMERGENCY		17,151,210	0	17,151,210	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		9,158,477	0	9,158,477	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (see instructions)		356,759,532	0	356,759,532	200.00
201.00	Less Observation Beds		9,158,477	0	9,158,477	201.00
202.00	Total (see instructions)		347,601,055	0	347,601,055	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019		Worksheet C Part I Date/Time Prepared: 6/30/2020 2:16 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	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	173,787,457		173,787,457				30.00
31.00	03100	INTENSIVE CARE UNIT	27,140,503		27,140,503				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	88,576,583		88,576,583				35.00
40.00	04000	SUBPROVIDER - IPF	11,651,668		11,651,668				40.00
43.00	04300	NURSERY	9,600,682		9,600,682				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	135,468,134	71,445,699	206,913,833	0.101237	0.000000		50.00
51.00	05100	RECOVERY ROOM	19,850,715	15,484,769	35,335,484	0.164582	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,486,133	0	26,486,133	0.482762	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,285,747	29,596,354	41,882,101	0.163582	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	14,070,579	22,589,730	36,660,309	0.072303	0.000000		55.00
57.00	05700	CT SCAN	26,050,357	50,294,103	76,344,460	0.033821	0.000000		57.00
58.00	05800	MRI	5,285,954	14,755,376	20,041,330	0.097663	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	4,477,421	0	4,477,421	0.058919	0.000000		59.00
60.00	06000	LABORATORY	80,770,477	48,085,351	128,855,828	0.099707	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	1,204,800	1,489,125	2,693,925	0.622773	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	25,521,296	2,650,296	28,171,592	0.213983	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,097,090	23,312,901	29,409,991	0.319337	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,422,496	3,359,313	8,781,809	0.291431	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,516,214	698,802	2,215,016	0.199023	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	10,265,627	1,847,249	12,112,876	0.065654	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,330,528	12,358,239	13,688,767	0.205450	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,136,816	25,009,062	77,145,878	0.362093	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,440,942	10,325,056	45,765,998	0.431133	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,808,216	45,996,603	123,804,819	0.244031	0.000000		73.00
73.01	07301	SPECIALTY PHARMACY	0	20,010,685	20,010,685	1.124052	0.000000		73.01
74.00	07400	RENAL DIALYSIS	4,194,423	0	4,194,423	0.417271	0.000000		74.00
76.00	03330	ENDOSCOPY	6,241,098	19,159,843	25,400,941	0.147039	0.000000		76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.03
76.04	03953	WOUND CARE	992,834	154,160	1,146,994	0.263316	0.000000		76.04
76.06	03954	IMAGING CENTER	523,953	59,304,897	59,828,850	0.085316	0.000000		76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	18,564	24,801,448	24,820,012	0.478585	0.000000		76.07
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	04950	INFUSION CENTER	0	619,794	619,794	0.529334	0.000000		90.01
90.26	04975	SPINE CENTER	0	633,756	633,756	0.527170	0.000000		90.26
91.00	09100	EMERGENCY	39,236,042	131,354,685	170,590,727	0.100540	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,133,956	9,599,617	12,733,573	0.719239	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	906,587,305	644,936,913	1,551,524,218				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	906,587,305	644,936,913	1,551,524,218				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/30/2020 2:16 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - I PF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.101237		50.00
51.00	05100	RECOVERY ROOM	0.164582		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482762		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163582		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072303		55.00
57.00	05700	CT SCAN	0.033821		57.00
58.00	05800	MRI	0.097663		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.058919		59.00
60.00	06000	LABORATORY	0.099707		60.00
64.00	06400	INTRAVENOUS THERAPY	0.622773		64.00
65.00	06500	RESPIRATORY THERAPY	0.213983		65.00
66.00	06600	PHYSICAL THERAPY	0.319337		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291431		67.00
68.00	06800	SPEECH PATHOLOGY	0.199023		68.00
69.00	06900	ELECTROCARDIOLOGY	0.065654		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.205450		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362093		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431133		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244031		73.00
73.01	07301	SPECIALTY PHARMACY	1.124052		73.01
74.00	07400	RENAL DIALYSIS	0.417271		74.00
76.00	03330	ENDOSCOPY	0.147039		76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.03
76.04	03953	WOUND CARE	0.263316		76.04
76.06	03954	IMAGING CENTER	0.085316		76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.478585		76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	INFUSION CENTER	0.529334		90.01
90.26	04975	SPINE CENTER	0.527170		90.26
91.00	09100	EMERGENCY	0.100540		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.719239		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
6/30/2020 2:16 pm

		Title XIX		Hospital		PPS
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	Total Costs
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	78,841,038		78,841,038	0	78,841,038
31.00	03100 INTENSIVE CARE UNIT	12,854,842		12,854,842	0	12,854,842
35.00	02060 NEONATAL INTENSIVE CARE UNIT	16,188,890		16,188,890	0	16,188,890
40.00	04000 SUBPROVIDER - IPF	4,670,729		4,670,729	0	4,670,729
43.00	04300 NURSERY	4,941,149		4,941,149	0	4,941,149
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	20,947,363		20,947,363	0	20,947,363
51.00	05100 RECOVERY ROOM	5,815,593		5,815,593	0	5,815,593
52.00	05200 DELIVERY ROOM & LABOR ROOM	12,786,503		12,786,503	0	12,786,503
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,851,170		6,851,170	0	6,851,170
55.00	05500 RADIOLOGY-THERAPEUTIC	2,650,639		2,650,639	0	2,650,639
57.00	05700 CT SCAN	2,582,015		2,582,015	0	2,582,015
58.00	05800 MRI	1,957,303		1,957,303	0	1,957,303
59.00	05900 CARDIAC CATHETERIZATION	263,805		263,805	0	263,805
60.00	06000 LABORATORY	12,847,866		12,847,866	0	12,847,866
64.00	06400 INTRAVENOUS THERAPY	1,677,703		1,677,703	0	1,677,703
65.00	06500 RESPIRATORY THERAPY	6,028,237	0	6,028,237	0	6,028,237
66.00	06600 PHYSICAL THERAPY	9,420,218	0	9,420,218	0	9,420,218
67.00	06700 OCCUPATIONAL THERAPY	2,559,289	0	2,559,289	0	2,559,289
68.00	06800 SPEECH PATHOLOGY	440,839	0	440,839	0	440,839
69.00	06900 ELECTROCARDIOLOGY	795,262		795,262	0	795,262
70.00	07000 ELECTROENCEPHALOGRAPHY	2,812,355		2,812,355	0	2,812,355
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27,933,945		27,933,945	0	27,933,945
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,731,241		19,731,241	0	19,731,241
73.00	07300 DRUGS CHARGED TO PATIENTS	30,212,259		30,212,259	0	30,212,259
73.01	07301 SPECIALTY PHARMACY	22,493,044		22,493,044	0	22,493,044
74.00	07400 RENAL DIALYSIS	1,750,211		1,750,211	0	1,750,211
76.00	03330 ENDOSCOPY	3,734,929		3,734,929	0	3,734,929
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0
76.04	03953 WOUND CARE	302,022		302,022	0	302,022
76.06	03954 IMAGING CENTER	5,104,356		5,104,356	0	5,104,356
76.07	03955 BREAST DIAGNOSTIC CENTER	11,878,493		11,878,493	0	11,878,493
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0
90.01	04950 INFUSION CENTER	328,078		328,078	0	328,078
90.26	04975 SPIRE CENTER	334,097		334,097	0	334,097
91.00	09100 EMERGENCY	17,271,125		17,271,125	0	17,271,125
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9,158,477		9,158,477	0	9,158,477
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
114.00	11400 UTILIZATION REVIEW-SNF					
200.00	Subtotal (see instructions)	358,165,085	0	358,165,085	0	358,165,085
201.00	Less Observation Beds	9,158,477		9,158,477		9,158,477
202.00	Total (see instructions)	349,006,608	0	349,006,608	0	349,006,608

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		9.00			10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	173,787,457		173,787,457		30.00
31.00	03100	INTENSIVE CARE UNIT	27,140,503		27,140,503		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	88,576,583		88,576,583		35.00
40.00	04000	SUBPROVIDER - IPF	11,651,668		11,651,668		40.00
43.00	04300	NURSERY	9,600,682		9,600,682		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	135,468,134	71,445,699	206,913,833	0.101237	50.00
51.00	05100	RECOVERY ROOM	19,850,715	15,484,769	35,335,484	0.164582	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,486,133	0	26,486,133	0.482762	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,285,747	29,596,354	41,882,101	0.163582	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	14,070,579	22,589,730	36,660,309	0.072303	55.00
57.00	05700	CT SCAN	26,050,357	50,294,103	76,344,460	0.033821	57.00
58.00	05800	MRI	5,285,954	14,755,376	20,041,330	0.097663	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,477,421	0	4,477,421	0.058919	59.00
60.00	06000	LABORATORY	80,770,477	48,085,351	128,855,828	0.099707	60.00
64.00	06400	INTRAVENOUS THERAPY	1,204,800	1,489,125	2,693,925	0.622773	64.00
65.00	06500	RESPIRATORY THERAPY	25,521,296	2,650,296	28,171,592	0.213983	65.00
66.00	06600	PHYSICAL THERAPY	6,097,090	23,312,901	29,409,991	0.320307	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,422,496	3,359,313	8,781,809	0.291431	67.00
68.00	06800	SPEECH PATHOLOGY	1,516,214	698,802	2,215,016	0.199023	68.00
69.00	06900	ELECTROCARDIOLOGY	10,265,627	1,847,249	12,112,876	0.065654	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,330,528	12,358,239	13,688,767	0.205450	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,136,816	25,009,062	77,145,878	0.362093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,440,942	10,325,056	45,765,998	0.431133	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,808,216	45,996,603	123,804,819	0.244031	73.00
73.01	07301	SPECIALTY PHARMACY	0	20,010,685	20,010,685	1.124052	73.01
74.00	07400	RENAL DIALYSIS	4,194,423	0	4,194,423	0.417271	74.00
76.00	03330	ENDOSCOPY	6,241,098	19,159,843	25,400,941	0.147039	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.03
76.04	03953	WOUND CARE	992,834	154,160	1,146,994	0.263316	76.04
76.06	03954	IMAGING CENTER	523,953	59,304,897	59,828,850	0.085316	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	18,564	24,801,448	24,820,012	0.478585	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	04950	INFUSION CENTER	0	619,794	619,794	0.529334	90.01
90.26	04975	SPINE CENTER	0	633,756	633,756	0.527170	90.26
91.00	09100	EMERGENCY	39,236,042	131,354,685	170,590,727	0.101243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,133,956	9,599,617	12,733,573	0.719239	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	906,587,305	644,936,913	1,551,524,218		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	906,587,305	644,936,913	1,551,524,218		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/30/2020 2:16 pm
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS			11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - I/PF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.101237		50.00
51.00	05100	RECOVERY ROOM	0.164582		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482762		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163582		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072303		55.00
57.00	05700	CT SCAN	0.033821		57.00
58.00	05800	MRI	0.097663		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.058919		59.00
60.00	06000	LABORATORY	0.099707		60.00
64.00	06400	INTRAVENOUS THERAPY	0.622773		64.00
65.00	06500	RESPIRATORY THERAPY	0.213983		65.00
66.00	06600	PHYSICAL THERAPY	0.320307		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291431		67.00
68.00	06800	SPEECH PATHOLOGY	0.199023		68.00
69.00	06900	ELECTROCARDIOLOGY	0.065654		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.205450		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362093		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431133		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244031		73.00
73.01	07301	SPECIALTY PHARMACY	1.124052		73.01
74.00	07400	RENAL DIALYSIS	0.417271		74.00
76.00	03330	ENDOSCOPY	0.147039		76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.03
76.04	03953	WOUND CARE	0.263316		76.04
76.06	03954	IMAGING CENTER	0.085316		76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.478585		76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	INFUSION CENTER	0.529334		90.01
90.26	04975	SPINE CENTER	0.527170		90.26
91.00	09100	EMERGENCY	0.101243		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.719239		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0169

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

Worksheet C
Part II
Date/Time Prepared:
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Cost Center Description			Title XIX			Hospital		PPS
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,947,363	3,568,927	17,378,436	0	0	50.00
51.00	05100	RECOVERY ROOM	5,815,593	588,831	5,226,762	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,786,503	1,647,210	11,139,293	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,851,170	811,268	6,039,902	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,650,639	766,433	1,884,206	0	0	55.00
57.00	05700	CT SCAN	2,582,015	333,063	2,248,952	0	0	57.00
58.00	05800	MRI	1,957,303	474,455	1,482,848	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	263,805	6,718	257,087	0	0	59.00
60.00	06000	LABORATORY	12,847,866	482,126	12,365,740	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,677,703	244,082	1,433,621	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,028,237	444,157	5,584,080	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,420,218	706,198	8,714,020	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,559,289	114,786	2,444,503	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	440,839	19,873	420,966	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	795,262	19,327	775,935	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,812,355	276,794	2,535,561	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,933,945	1,623,045	26,310,900	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,731,241	1,147,254	18,583,987	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,212,259	1,437,335	28,774,924	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	22,493,044	535,100	21,957,944	0	0	73.01
74.00	07400	RENAL DIALYSIS	1,750,211	37,527	1,712,684	0	0	74.00
76.00	03330	ENDOSCOPY	3,734,929	656,996	3,077,933	0	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	302,022	8,141	293,881	0	0	76.04
76.06	03954	IMAGING CENTER	5,104,356	464,157	4,640,199	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	11,878,493	247,325	11,631,168	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	328,078	40,631	287,447	0	0	90.01
90.26	04975	SPIRE CENTER	334,097	7,487	326,610	0	0	90.26
91.00	09100	EMERGENCY	17,271,125	1,347,421	15,923,704	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,158,477	955,980	8,202,497	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (sum of lines 50 thru 199)	240,668,437	19,012,647	221,655,790	0	0	200.00
201.00		Less Observation Beds	9,158,477	955,980	8,202,497	0	0	201.00
202.00		Total (line 200 minus line 201)	231,509,960	18,056,667	213,453,293	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0169

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

Worksheet C
Part II
Date/Time Prepared:
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	20,947,363	206,913,833	0.101237		50.00
51.00	05100 RECOVERY ROOM	5,815,593	35,335,484	0.164582		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	12,786,503	26,486,133	0.482762		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,851,170	41,882,101	0.163582		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,650,639	36,660,309	0.072303		55.00
57.00	05700 CT SCAN	2,582,015	76,344,460	0.033821		57.00
58.00	05800 MRI	1,957,303	20,041,330	0.097663		58.00
59.00	05900 CARDIAC CATHETERIZATION	263,805	4,477,421	0.058919		59.00
60.00	06000 LABORATORY	12,847,866	128,855,828	0.099707		60.00
64.00	06400 INTRAVENOUS THERAPY	1,677,703	2,693,925	0.622773		64.00
65.00	06500 RESPIRATORY THERAPY	6,028,237	28,171,592	0.213983		65.00
66.00	06600 PHYSICAL THERAPY	9,420,218	29,409,991	0.320307		66.00
67.00	06700 OCCUPATIONAL THERAPY	2,559,289	8,781,809	0.291431		67.00
68.00	06800 SPEECH PATHOLOGY	440,839	2,215,016	0.199023		68.00
69.00	06900 ELECTROCARDIOLOGY	795,262	12,112,876	0.065654		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,812,355	13,688,767	0.205450		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27,933,945	77,145,878	0.362093		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,731,241	45,765,998	0.431133		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	30,212,259	123,804,819	0.244031		73.00
73.01	07301 SPECIALTY PHARMACY	22,493,044	20,010,685	1.124052		73.01
74.00	07400 RENAL DIALYSIS	1,750,211	4,194,423	0.417271		74.00
76.00	03330 ENDOSCOPY	3,734,929	25,400,941	0.147039		76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.03
76.04	03953 WOUND CARE	302,022	1,146,994	0.263316		76.04
76.06	03954 IMAGING CENTER	5,104,356	59,828,850	0.085316		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	11,878,493	24,820,012	0.478585		76.07
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000		90.00
90.01	04950 INFUSION CENTER	328,078	619,794	0.529334		90.01
90.26	04975 SPINE CENTER	334,097	633,756	0.527170		90.26
91.00	09100 EMERGENCY	17,271,125	170,590,727	0.101243		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9,158,477	12,733,573	0.719239		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (sum of lines 50 thru 199)	240,668,437	1,240,767,325			200.00
201.00	Less Observation Beds	9,158,477	0			201.00
202.00	Total (line 200 minus line 201)	231,509,960	1,240,767,325			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part I Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description		Title XVIII			Hospital		Per Diem (col. 3 / col. 4)	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	8,140,148	0	8,140,148	65,148	124.95	30.00	
31.00	INTENSIVE CARE UNIT	1,656,112		1,656,112	6,544	253.07	31.00	
35.00	NEONATAL INTENSIVE CARE UNIT	1,608,969		1,608,969	11,655	138.05	35.00	
40.00	SUBPROVIDER - IPF	316,012	0	316,012	5,142	61.46	40.00	
43.00	NURSERY	620,889		620,889	7,388	84.04	43.00	
200.00	Total (lines 30 through 199)	12,342,130		12,342,130	95,877		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	18,645	2,329,693					
31.00	INTENSIVE CARE UNIT	2,102	531,953					
35.00	NEONATAL INTENSIVE CARE UNIT	0	0					
40.00	SUBPROVIDER - IPF	2,786	171,228					
43.00	NURSERY	0	0					
200.00	Total (lines 30 through 199)	23,533	3,032,874					

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 6/30/2020 2:16 pm
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,568,927	206,913,833	0.017248	44,190,169	762,192	50.00
51.00	05100 RECOVERY ROOM	588,831	35,335,484	0.016664	4,962,874	82,701	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,647,210	26,486,133	0.062191	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	811,268	41,882,101	0.019370	3,781,948	73,256	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	766,433	36,660,309	0.020906	6,110,345	127,743	55.00
57.00	05700 CT SCAN	333,063	76,344,460	0.004363	9,690,643	42,280	57.00
58.00	05800 MRI	474,455	20,041,330	0.023674	1,656,514	39,216	58.00
59.00	05900 CARDIAC CATHETERIZATION	6,718	4,477,421	0.001500	2,540,199	3,810	59.00
60.00	06000 LABORATORY	482,126	128,855,828	0.003742	26,495,078	99,145	60.00
64.00	06400 INTRAVENOUS THERAPY	244,082	2,693,925	0.090605	397,926	36,054	64.00
65.00	06500 RESPIRATORY THERAPY	444,157	28,171,592	0.015766	6,113,643	96,388	65.00
66.00	06600 PHYSICAL THERAPY	706,198	29,409,991	0.024012	2,595,691	62,328	66.00
67.00	06700 OCCUPATIONAL THERAPY	114,786	8,781,809	0.013071	1,888,608	24,686	67.00
68.00	06800 SPEECH PATHOLOGY	19,873	2,215,016	0.008972	540,726	4,851	68.00
69.00	06900 ELECTROCARDIOLOGY	19,327	12,112,876	0.001596	4,396,112	7,016	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	276,794	13,688,767	0.020221	319,595	6,463	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,623,045	77,145,878	0.021039	9,914,981	208,601	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,147,254	45,765,998	0.025068	13,827,324	346,623	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,437,335	123,804,819	0.011610	25,425,446	295,189	73.00
73.01	07301 SPECIALTY PHARMACY	535,100	20,010,685	0.026741	0	0	73.01
74.00	07400 RENAL DIALYSIS	37,527	4,194,423	0.008947	1,758,152	15,730	74.00
76.00	03330 ENDOSCOPY	656,996	25,400,941	0.025865	2,544,825	65,822	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03
76.04	03953 WOUND CARE	8,141	1,146,994	0.007098	416,603	2,957	76.04
76.06	03954 IMAGING CENTER	464,157	59,828,850	0.007758	44,538	346	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	247,325	24,820,012	0.009965	1,419	14	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	04950 INFUSION CENTER	40,631	619,794	0.065556	0	0	90.01
90.26	04975 SPINE CENTER	7,487	633,756	0.011814	0	0	90.26
91.00	09100 EMERGENCY	1,347,421	170,590,727	0.007899	15,012,435	118,583	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	955,980	12,733,573	0.075076	1,216,555	91,334	92.00
200.00	Total (lines 50 through 199)	19,012,647	1,240,767,325		185,842,349	2,613,328	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 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	65,148	0.00	18,645	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	6,544	0.00	2,102	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	11,655	0.00	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	5,142	0.00	2,786	40.00	
43.00	04300	NURSERY	0	0	7,388	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	95,877	0.00	23,533	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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
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: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description	Title XVIII			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	0	0	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.03
76.04 03953 WOUND CARE	0	0	0	0	0	0	76.04
76.06 03954 IMAGING CENTER	0	0	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
90.01 04950 INFUSION CENTER	0	0	0	0	0	0	90.01
90.26 04975 SPINE CENTER	0	0	0	0	0	0	90.26
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	206,913,833	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	35,335,484	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	26,486,133	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,882,101	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	36,660,309	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	76,344,460	0.000000	57.00
58.00 05800 MRI	0	0	0	20,041,330	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	4,477,421	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	128,855,828	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	2,693,925	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	28,171,592	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	29,409,991	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	8,781,809	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,215,016	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	12,112,876	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	13,688,767	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	77,145,878	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,765,998	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	123,804,819	0.000000	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	20,010,685	0.000000	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	4,194,423	0.000000	74.00
76.00 03330 ENDOSCOPY	0	0	0	25,400,941	0.000000	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04 03953 WOUND CARE	0	0	0	1,146,994	0.000000	76.04
76.06 03954 IMAGING CENTER	0	0	0	59,828,850	0.000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	24,820,012	0.000000	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 INFUSION CENTER	0	0	0	619,794	0.000000	90.01
90.26 04975 SPINE CENTER	0	0	0	633,756	0.000000	90.26
91.00 09100 EMERGENCY	0	0	0	170,590,727	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,733,573	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	1,240,767,325		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm
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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	44,190,169	0	16,044,379	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	4,962,874	0	2,581,190	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,781,948	0	5,333,392	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	6,110,345	0	10,446,818	0	55.00
57.00	05700 CT SCAN	0.000000	9,690,643	0	10,046,667	0	57.00
58.00	05800 MRI	0.000000	1,656,514	0	3,387,761	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	2,540,199	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	26,495,078	0	8,667,086	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	397,926	0	468,211	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	6,113,643	0	354,296	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,595,691	0	113,715	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,888,608	0	27,627	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	540,726	0	7,317	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	4,396,112	0	429,942	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	319,595	0	2,760,800	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	9,914,981	0	5,315,183	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	13,827,324	0	3,426,807	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	25,425,446	0	14,645,826	0	73.00
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	1,758,152	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	2,544,825	0	5,622,571	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953 WOUND CARE	0.000000	416,603	0	66,778	0	76.04
76.06	03954 IMAGING CENTER	0.000000	44,538	0	16,776,310	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	1,419	0	2,619,919	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0.000000	0	0	13,496	0	90.01
90.26	04975 SPINE CENTER	0.000000	0	0	388	0	90.26
91.00	09100 EMERGENCY	0.000000	15,012,435	0	17,016,068	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,216,555	0	5,385,052	0	92.00
200.00	Total (lines 50 through 199)		185,842,349	0	131,557,599	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0169

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

Worksheet D
Part V
Date/Time Prepared:
6/30/2020 2:16 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	0.101237	16,044,379	0	0	1,624,285	50.00
51.00	05100 RECOVERY ROOM	0.164582	2,581,190	0	0	424,817	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.482762	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.163582	5,333,392	0	0	872,447	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.072303	10,446,818	0	0	755,336	55.00
57.00	05700 CT SCAN	0.033821	10,046,667	0	0	339,788	57.00
58.00	05800 MRI	0.097663	3,387,761	0	0	330,859	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.058919	0	0	0	0	59.00
60.00	06000 LABORATORY	0.099707	8,667,086	0	0	864,169	60.00
64.00	06400 INTRAVENOUS THERAPY	0.622773	468,211	0	0	291,589	64.00
65.00	06500 RESPIRATORY THERAPY	0.213983	354,296	0	0	75,813	65.00
66.00	06600 PHYSICAL THERAPY	0.319337	113,715	0	0	36,313	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.291431	27,627	0	0	8,051	67.00
68.00	06800 SPEECH PATHOLOGY	0.199023	7,317	0	0	1,456	68.00
69.00	06900 ELECTROCARDIOLOGY	0.065654	429,942	0	0	28,227	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.205450	2,760,800	0	0	567,206	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.362093	5,315,183	0	0	1,924,591	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.431133	3,426,807	0	0	1,477,410	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.244031	14,645,826	0	70,267	3,574,036	73.00
73.01	07301 SPECIALTY PHARMACY	1.124052	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.417271	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.147039	5,622,571	0	0	826,737	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953 WOUND CARE	0.263316	66,778	0	0	17,584	76.04
76.06	03954 IMAGING CENTER	0.085316	16,776,310	0	0	1,431,288	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.478585	2,619,919	0	0	1,253,854	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0.529334	13,496	0	0	7,144	90.01
90.26	04975 SPINE CENTER	0.527170	388	0	0	205	90.26
91.00	09100 EMERGENCY	0.100540	17,016,068	0	114	1,710,795	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.719239	5,385,052	0	0	3,873,139	92.00
200.00	Subtotal (see instructions)		131,557,599	0	70,381	22,317,139	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		131,557,599	0	70,381	22,317,139	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/30/2020 2:16 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
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
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
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	17,147		73.00
73.01 07301 SPECIALTY PHARMACY	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	0	0		76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.03
76.04 03953 WOUND CARE	0	0		76.04
76.06 03954 IMAGING CENTER	0	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		76.07
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 INFUSION CENTER	0	0		90.01
90.26 04975 SPINE CENTER	0	0		90.26
91.00 09100 EMERGENCY	0	11		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	17,158		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	17,158		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 6/30/2020 2:16 pm
Title XVIII			Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,568,927	206,913,833	0.017248	0	50.00
51.00	05100	RECOVERY ROOM	588,831	35,335,484	0.016664	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,647,210	26,486,133	0.062191	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,268	41,882,101	0.019370	34,272	664 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	766,433	36,660,309	0.020906	0	55.00
57.00	05700	CT SCAN	333,063	76,344,460	0.004363	85,336	372 57.00
58.00	05800	MRI	474,455	20,041,330	0.023674	7,409	175 58.00
59.00	05900	CARDIAC CATHETERIZATION	6,718	4,477,421	0.001500	0	59.00
60.00	06000	LABORATORY	482,126	128,855,828	0.003742	851,356	3,186 60.00
64.00	06400	INTRAVENOUS THERAPY	244,082	2,693,925	0.090605	22,741	2,060 64.00
65.00	06500	RESPIRATORY THERAPY	444,157	28,171,592	0.015766	19,527	308 65.00
66.00	06600	PHYSICAL THERAPY	706,198	29,409,991	0.024012	52,109	1,251 66.00
67.00	06700	OCCUPATIONAL THERAPY	114,786	8,781,809	0.013071	51,116	668 67.00
68.00	06800	SPEECH PATHOLOGY	19,873	2,215,016	0.008972	6,506	58 68.00
69.00	06900	ELECTROCARDIOLOGY	19,327	12,112,876	0.001596	20,156	32 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	276,794	13,688,767	0.020221	1,811	37 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,623,045	77,145,878	0.021039	70,356	1,480 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,147,254	45,765,998	0.025068	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,437,335	123,804,819	0.011610	499,111	5,795 73.00
73.01	07301	SPECIALTY PHARMACY	535,100	20,010,685	0.026741	0	0 73.01
74.00	07400	RENAL DIALYSIS	37,527	4,194,423	0.008947	0	0 74.00
76.00	03330	ENDOSCOPY	656,996	25,400,941	0.025865	0	0 76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0 76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0 76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0 76.03
76.04	03953	WOUND CARE	8,141	1,146,994	0.007098	0	0 76.04
76.06	03954	IMAGING CENTER	464,157	59,828,850	0.007758	0	0 76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	247,325	24,820,012	0.009965	0	0 76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0 90.00
90.01	04950	INFUSION CENTER	40,631	619,794	0.065556	0	0 90.01
90.26	04975	SPINE CENTER	7,487	633,756	0.011814	0	0 90.26
91.00	09100	EMERGENCY	1,347,421	170,590,727	0.007899	377,837	2,985 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,733,573	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	18,056,667	1,240,767,325		2,099,643	19,071 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
73.01 07301 SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	0	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04 03953 WOUND CARE	0	0	0	0	0	76.04
76.06 03954 IMAGING CENTER	0	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 04950 INFUSION CENTER	0	0	0	0	0	90.01
90.26 04975 SPINE CENTER	0	0	0	0	0	90.26
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
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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm
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Title XVIII		Subprovider - IPF	PPS
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Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	206,913,833	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	35,335,484	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	26,486,133	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,882,101	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	36,660,309	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	76,344,460	0.000000	57.00
58.00	05800	MRI	0	0	0	20,041,330	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	4,477,421	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	128,855,828	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,693,925	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	28,171,592	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	29,409,991	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,781,809	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,215,016	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	12,112,876	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	13,688,767	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	77,145,878	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,765,998	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	123,804,819	0.000000	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	20,010,685	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	4,194,423	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	25,400,941	0.000000	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04	03953	WOUND CARE	0	0	0	1,146,994	0.000000	76.04
76.06	03954	IMAGING CENTER	0	0	0	59,828,850	0.000000	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	24,820,012	0.000000	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	INFUSION CENTER	0	0	0	619,794	0.000000	90.01
90.26	04975	SPINE CENTER	0	0	0	633,756	0.000000	90.26
91.00	09100	EMERGENCY	0	0	0	170,590,727	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,733,573	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,240,767,325		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0169 Component CCN: 15-S169		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm	
				Title XVIII		Subprovider - IPF	
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	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	34,272	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	85,336	0	0	57.00
58.00	05800	MRI	0.000000	7,409	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	851,356	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	22,741	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	19,527	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	52,109	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	51,116	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,506	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	20,156	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,811	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	70,356	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	499,111	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	0.000000	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.03
76.04	03953	WOUND CARE	0.000000	0	0	0	76.04
76.06	03954	IMAGING CENTER	0.000000	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.000000	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.01	04950	INFUSION CENTER	0.000000	0	0	0	90.01
90.26	04975	SPINE CENTER	0.000000	0	0	0	90.26
91.00	09100	EMERGENCY	0.000000	377,837	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,099,643	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/30/2020 2:16 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.101237	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.164582	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.482762	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.163582	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.072303	0	0	0	0	55.00
57.00 05700 CT SCAN	0.033821	0	0	0	0	57.00
58.00 05800 MRI	0.097663	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.058919	0	0	0	0	59.00
60.00 06000 LABORATORY	0.099707	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.622773	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.213983	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.319337	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.291431	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.199023	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.065654	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.205450	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.362093	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.431133	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.244031	0	0	3,339	0	73.00
73.01 07301 SPECIALTY PHARMACY	1.124052	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0.417271	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0.147039	0	0	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04 03953 WOUND CARE	0.263316	0	0	0	0	76.04
76.06 03954 IMAGING CENTER	0.085316	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0.478585	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 04950 INFUSION CENTER	0.529334	0	0	0	0	90.01
90.26 04975 SPINE CENTER	0.527170	0	0	0	0	90.26
91.00 09100 EMERGENCY	0.100540	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.719239	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	3,339	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 - line 201)		0	0	3,339	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/30/2020 2:16 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
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	815	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
76.04 03953 WOUND CARE	0	0	76.04
76.06 03954 IMAGING CENTER	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	76.07
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 04950 INFUSION CENTER	0	0	90.01
90.26 04975 SPINE CENTER	0	0	90.26
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	815	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	815	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part I Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description		Title XIX			Hospital		Per Diem (col. 3 / col. 4)	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	8,140,148	0	8,140,148	65,148	124.95	30.00	
31.00	INTENSIVE CARE UNIT	1,656,112		1,656,112	6,544	253.07	31.00	
35.00	NEONATAL INTENSIVE CARE UNIT	1,608,969		1,608,969	11,655	138.05	35.00	
40.00	SUBPROVIDER - IPF	316,012	0	316,012	5,142	61.46	40.00	
43.00	NURSERY	620,889		620,889	7,388	84.04	43.00	
200.00	Total (lines 30 through 199)	12,342,130		12,342,130	95,877		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	2,470	308,627					
31.00	INTENSIVE CARE UNIT	0	0					
35.00	NEONATAL INTENSIVE CARE UNIT	1,717	237,032					
40.00	SUBPROVIDER - IPF	0	0					
43.00	NURSERY	2,781	233,715					
200.00	Total (lines 30 through 199)	6,968	779,374					

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,568,927	206,913,833	0.017248	2,374,707	40,959	50.00
51.00	05100	RECOVERY ROOM	588,831	35,335,484	0.016664	416,407	6,939	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,647,210	26,486,133	0.062191	578,375	35,970	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,268	41,882,101	0.019370	602,217	11,665	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	766,433	36,660,309	0.020906	322,391	6,740	55.00
57.00	05700	CT SCAN	333,063	76,344,460	0.004363	1,215,313	5,302	57.00
58.00	05800	MRI	474,455	20,041,330	0.023674	328,109	7,768	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,718	4,477,421	0.001500	218,580	328	59.00
60.00	06000	LABORATORY	482,126	128,855,828	0.003742	4,030,856	15,083	60.00
64.00	06400	INTRAVENOUS THERAPY	244,082	2,693,925	0.090605	77,412	7,014	64.00
65.00	06500	RESPIRATORY THERAPY	444,157	28,171,592	0.015766	2,059,098	32,464	65.00
66.00	06600	PHYSICAL THERAPY	706,198	29,409,991	0.024012	156,664	3,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,786	8,781,809	0.013071	306,274	4,003	67.00
68.00	06800	SPEECH PATHOLOGY	19,873	2,215,016	0.008972	99,121	889	68.00
69.00	06900	ELECTROCARDIOLOGY	19,327	12,112,876	0.001596	436,492	697	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	276,794	13,688,767	0.020221	125,440	2,537	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,623,045	77,145,878	0.021039	1,335,639	28,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,147,254	45,765,998	0.025068	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,437,335	123,804,819	0.011610	4,131,775	47,970	73.00
73.01	07301	SPECIALTY PHARMACY	535,100	20,010,685	0.026741	0	0	73.01
74.00	07400	RENAL DIALYSIS	37,527	4,194,423	0.008947	133,333	1,193	74.00
76.00	03330	ENDOSCOPY	656,996	25,400,941	0.025865	239,626	6,198	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03
76.04	03953	WOUND CARE	8,141	1,146,994	0.007098	46,925	333	76.04
76.06	03954	IMAGING CENTER	464,157	59,828,850	0.007758	6,095	47	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	247,325	24,820,012	0.009965	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	INFUSION CENTER	40,631	619,794	0.065556	0	0	90.01
90.26	04975	SPINE CENTER	7,487	633,756	0.011814	0	0	90.26
91.00	09100	EMERGENCY	1,347,421	170,590,727	0.007899	1,920,647	15,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	955,982	12,733,573	0.075076	80,105	6,014	92.00
200.00		Total (lines 50 through 199)	19,012,649	1,240,767,325		21,241,601	287,147	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	65,148	0.00	2,470	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	6,544	0.00	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	11,655	0.00	1,717	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	5,142	0.00	0	40.00	
43.00	04300	NURSERY	0	0	7,388	0.00	2,781	43.00	
200.00		Total (lines 30 through 199)	0	0	95,877	0.00	6,968	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
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: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description	Title XIX				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	0	0	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.03
76.04 03953 WOUND CARE	0	0	0	0	0	0	76.04
76.06 03954 IMAGING CENTER	0	0	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
90.01 04950 INFUSION CENTER	0	0	0	0	0	0	90.01
90.26 04975 SPINE CENTER	0	0	0	0	0	0	90.26
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description	Title XIX			Hospital	PPS	
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	206,913,833	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	35,335,484	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	26,486,133	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,882,101	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	36,660,309	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	76,344,460	0.000000	57.00
58.00 05800 MRI	0	0	0	20,041,330	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	4,477,421	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	128,855,828	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	2,693,925	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	28,171,592	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	29,409,991	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	8,781,809	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,215,016	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	12,112,876	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	13,688,767	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	77,145,878	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,765,998	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	123,804,819	0.000000	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	20,010,685	0.000000	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	4,194,423	0.000000	74.00
76.00 03330 ENDOSCOPY	0	0	0	25,400,941	0.000000	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04 03953 WOUND CARE	0	0	0	1,146,994	0.000000	76.04
76.06 03954 IMAGING CENTER	0	0	0	59,828,850	0.000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	24,820,012	0.000000	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 INFUSION CENTER	0	0	0	619,794	0.000000	90.01
90.26 04975 SPINE CENTER	0	0	0	633,756	0.000000	90.26
91.00 09100 EMERGENCY	0	0	0	170,590,727	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,733,573	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	1,240,767,325		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/30/2020 2:16 pm
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Cost Center Description		Title XIX			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	2,374,707	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	416,407	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	578,375	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	602,217	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	322,391	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	1,215,313	0	0	0	57.00
58.00	05800 MRI	0.000000	328,109	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	218,580	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	4,030,856	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	77,412	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	2,059,098	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	156,664	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	306,274	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	99,121	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	436,492	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	125,440	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,335,639	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	4,131,775	0	0	0	73.00
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	133,333	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	239,626	0	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953 WOUND CARE	0.000000	46,925	0	0	0	76.04
76.06	03954 IMAGING CENTER	0.000000	6,095	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0.000000	0	0	0	0	90.01
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.000000	1,920,647	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	80,105	0	0	0	92.00
200.00	Total (lines 50 through 199)		21,241,601	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0169

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

Worksheet D
Part V
Date/Time Prepared:
6/30/2020 2:16 pm

		Title XIX		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCI LLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.101237	0	1,723,933	0	0	50.00
51.00	05100	RECOVERY ROOM	0.164582	0	444,316	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482762	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163582	0	1,172,847	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072303	0	467,989	0	0	55.00
57.00	05700	CT SCAN	0.033821	0	2,682,609	0	0	57.00
58.00	05800	MRI	0.097663	0	236,602	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.058919	0	0	0	0	59.00
60.00	06000	LABORATORY	0.099707	0	2,829,774	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.622773	0	15,912	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.213983	0	102,628	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.320307	0	211,076	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291431	0	63,261	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.199023	0	35,966	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065654	0	66,310	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.205450	0	161,313	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362093	0	434,687	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431133	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244031	0	1,244,242	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	1.124052	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.417271	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.147039	0	244,179	0	0	76.00
76.01	03950	OTHER ANCI LLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951	OTHER ANCI LLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952	OTHER ANCI LLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953	WOUND CARE	0.263316	0	4,046	0	0	76.04
76.06	03954	IMAGING CENTER	0.085316	0	544,077	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.478585	0	176,223	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	0.529334	0	0	0	0	90.01
90.26	04975	SPINE CENTER	0.527170	0	0	0	0	90.26
91.00	09100	EMERGENCY	0.101243	0	10,436,312	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.719239	0	10,220	0	0	92.00
200.00		Subtotal (see instructions)		0	23,308,522	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	23,308,522	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/30/2020 2:16 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	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	174,526	0		50.00
51.00 05100 RECOVERY ROOM	73,126	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	191,857	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	33,837	0		55.00
57.00 05700 CT SCAN	90,729	0		57.00
58.00 05800 MRI	23,107	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	282,148	0		60.00
64.00 06400 INTRAVENOUS THERAPY	9,910	0		64.00
65.00 06500 RESPIRATORY THERAPY	21,961	0		65.00
66.00 06600 PHYSICAL THERAPY	67,609	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	18,436	0		67.00
68.00 06800 SPEECH PATHOLOGY	7,158	0		68.00
69.00 06900 ELECTROCARDIOLOGY	4,354	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	33,142	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	157,397	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	303,634	0		73.00
73.01 07301 SPECIALTY PHARMACY	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	35,904	0		76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.03
76.04 03953 WOUND CARE	1,065	0		76.04
76.06 03954 IMAGING CENTER	46,418	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	84,338	0		76.07
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 INFUSION CENTER	0	0		90.01
90.26 04975 SPINE CENTER	0	0		90.26
91.00 09100 EMERGENCY	1,056,604	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7,351	0		92.00
200.00 Subtotal (see instructions)	2,724,611	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	2,724,611	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/30/2020 2:16 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		65,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		65,148	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)		57,497	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)		18,645	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)		77,984,250	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)		77,984,250	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)		77,984,250	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)		1,197.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		22,318,624	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)		22,318,624	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/30/2020 2:16 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	12,854,842	6,544	1,964.37	2,102	4,129,106	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	16,188,890	11,655	1,389.01	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					32,391,600	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					58,839,330	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)					2,861,646	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,613,328	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,474,974	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53,364,356	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)					7,651	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,197.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					9,158,477	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 6/30/2020 2:16 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	8,140,148	77,984,250	0.104382	9,158,477	955,980	90.00
91.00	Nursing School cost	0	77,984,250	0.000000	9,158,477	0	91.00
92.00	Allied health cost	0	77,984,250	0.000000	9,158,477	0	92.00
93.00	All other Medical Education	0	77,984,250	0.000000	9,158,477	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/30/2020 2:16 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)		5,142	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,142	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)		5,142	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)		2,786	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)		4,270,394	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)		4,270,394	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)		4,270,394	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)		830.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,313,745	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)		2,313,745	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/30/2020 2:16 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						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					332,231	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,645,976	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)					171,228	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					19,071	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					190,299	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,455,677	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: 15-0169 Component CCN: 15-S169		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 6/30/2020 2:16 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	316,012	4,270,394	0.074001	0	0	90.00
91.00	Nursing School cost	0	4,270,394	0.000000	0	0	91.00
92.00	Allied health cost	0	4,270,394	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,270,394	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/30/2020 2:16 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		65,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		65,148	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)		57,497	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)		2,470	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)		7,388	15.00
16.00	Nursery days (title V or XIX only)		2,781	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)		78,841,038	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)		78,841,038	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)		78,841,038	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)		1,210.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,989,145	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)		2,989,145	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/30/2020 2:16 pm
Title XIX				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)	4,941,149	7,388	668.81	2,781	1,859,961	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	12,854,842	6,544	1,964.37	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 NEONATAL INTENSIVE CARE UNIT	16,188,890	11,655	1,389.01	1,717	2,384,930	47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,748,048	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,982,084	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)					779,374	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					287,147	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,066,521	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,915,563	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)					7,651	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,210.18	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					9,259,087	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0169

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

Worksheet D-1

Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description	Cost	Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	8,140,148	78,841,038	0.103248	9,259,087	955,982	90.00
91.00 Nursing School cost	0	78,841,038	0.000000	9,259,087	0	91.00
92.00 Allied health cost	0	78,841,038	0.000000	9,259,087	0	92.00
93.00 All other Medical Education	0	78,841,038	0.000000	9,259,087	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/30/2020 2:16 pm	
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		38,988,921	30.00
31.00	03100	INTENSIVE CARE UNIT		8,684,298	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.101237	44,190,169	50.00
51.00	05100	RECOVERY ROOM	0.164582	4,962,874	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482762	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163582	3,781,948	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072303	6,110,345	55.00
57.00	05700	CT SCAN	0.033821	9,690,643	57.00
58.00	05800	MRI	0.097663	1,656,514	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.058919	2,540,199	59.00
60.00	06000	LABORATORY	0.099707	26,495,078	60.00
64.00	06400	INTRAVENOUS THERAPY	0.622773	397,926	64.00
65.00	06500	RESPIRATORY THERAPY	0.213983	6,113,643	65.00
66.00	06600	PHYSICAL THERAPY	0.319337	2,595,691	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291431	1,888,608	67.00
68.00	06800	SPEECH PATHOLOGY	0.199023	540,726	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065654	4,396,112	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.205450	319,595	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362093	9,914,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431133	13,827,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244031	25,425,446	73.00
73.01	07301	SPECIALTY PHARMACY	1.124052	0	73.01
74.00	07400	RENAL DIALYSIS	0.417271	1,758,152	74.00
76.00	03330	ENDOSCOPY	0.147039	2,544,825	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.03
76.04	03953	WOUND CARE	0.263316	416,603	76.04
76.06	03954	IMAGING CENTER	0.085316	44,538	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.478585	1,419	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	04950	INFUSION CENTER	0.529334	0	90.01
90.26	04975	SPINE CENTER	0.527170	0	90.26
91.00	09100	EMERGENCY	0.100540	15,012,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.719239	1,216,555	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		185,842,349	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)		185,842,349	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/30/2020 2:16 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - IPF		6,323,290	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.101237	0	50.00
51.00	05100	RECOVERY ROOM	0.164582	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482762	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163582	34,272	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072303	0	55.00
57.00	05700	CT SCAN	0.033821	85,336	57.00
58.00	05800	MRI	0.097663	7,409	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.058919	0	59.00
60.00	06000	LABORATORY	0.099707	851,356	60.00
64.00	06400	INTRAVENOUS THERAPY	0.622773	22,741	64.00
65.00	06500	RESPIRATORY THERAPY	0.213983	19,527	65.00
66.00	06600	PHYSICAL THERAPY	0.319337	52,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291431	51,116	67.00
68.00	06800	SPEECH PATHOLOGY	0.199023	6,506	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065654	20,156	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.205450	1,811	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362093	70,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431133	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244031	499,111	73.00
73.01	07301	SPECIALTY PHARMACY	1.124052	0	73.01
74.00	07400	RENAL DIALYSIS	0.417271	0	74.00
76.00	03330	ENDOSCOPY	0.147039	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.03
76.04	03953	WOUND CARE	0.263316	0	76.04
76.06	03954	IMAGING CENTER	0.085316	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.478585	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	04950	INFUSION CENTER	0.529334	0	90.01
90.26	04975	SPINE CENTER	0.527170	0	90.26
91.00	09100	EMERGENCY	0.100540	377,837	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.719239	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,099,643	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)		2,099,643	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/30/2020 2:16 pm	
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		7,467,126		30.00
31.00	03100 INTENSIVE CARE UNIT		2,022,237		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		14,065,021		35.00
40.00	04000 SUBPROVIDER - IPF		440,685		40.00
43.00	04300 NURSERY		487,754		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.101237	2,374,707	240,408	50.00
51.00	05100 RECOVERY ROOM	0.164582	416,407	68,533	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.482762	578,375	279,217	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.163582	602,217	98,512	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.072303	322,391	23,310	55.00
57.00	05700 CT SCAN	0.033821	1,215,313	41,103	57.00
58.00	05800 MRI	0.097663	328,109	32,044	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.058919	218,580	12,879	59.00
60.00	06000 LABORATORY	0.099707	4,030,856	401,905	60.00
64.00	06400 INTRAVENOUS THERAPY	0.622773	77,412	48,210	64.00
65.00	06500 RESPIRATORY THERAPY	0.213983	2,059,098	440,612	65.00
66.00	06600 PHYSICAL THERAPY	0.320307	156,664	50,181	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.291431	306,274	89,258	67.00
68.00	06800 SPEECH PATHOLOGY	0.199023	99,121	19,727	68.00
69.00	06900 ELECTROCARDIOLOGY	0.065654	436,492	28,657	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.205450	125,440	25,772	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.362093	1,335,639	483,626	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.431133	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.244031	4,131,775	1,008,281	73.00
73.01	07301 SPECIALTY PHARMACY	1.124052	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.417271	133,333	55,636	74.00
76.00	03330 ENDOSCOPY	0.147039	239,626	35,234	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.03
76.04	03953 WOUND CARE	0.263316	46,925	12,356	76.04
76.06	03954 IMAGING CENTER	0.085316	6,095	520	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.478585	0	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 INFUSION CENTER	0.529334	0	0	90.01
90.26	04975 SPINE CENTER	0.527170	0	0	90.26
91.00	09100 EMERGENCY	0.101243	1,920,647	194,452	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.719239	80,105	57,615	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		21,241,601	3,748,048	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		21,241,601		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/30/2020 2:16 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)		31,974,009	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,288,911	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		848,647	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		153,891	2.04
3.00	Managed Care Simulated Payments		17,526,950	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		287.92	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		3.49	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		3.49	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		3.49	10.00
11.00	FTE count for residents in dental and podiatric programs.		2.65	11.00
12.00	Current year allowable FTE (see instructions)		6.14	12.00
13.00	Total allowable FTE count for the prior year.		5.39	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.		4.94	14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.49	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		5.49	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.019068	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.020651	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.019068	21.00
22.00	IME payment adjustment (see instructions)		438,140	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		181,702	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		438,140	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		181,702	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.66	30.00
31.00	Percentage of Medicaid patient days (see instructions)		30.99	31.00
32.00	Sum of lines 30 and 31		34.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)		17.80	33.00
34.00	Disproportionate share adjustment (see instructions)		1,880,701	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/30/2020 2:16 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000343050	0.000049391	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,838,009	412,446	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	2,122,675	103,675	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,226,350		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	47,810,649		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)		47,992,351	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,826,018	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).		147,930	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)		51,966,299	59.00
60.00	Primary payer payments		14,465	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		51,951,834	61.00
62.00	Deductibles billed to program beneficiaries		4,167,352	62.00
63.00	Coinurance billed to program beneficiaries		148,670	63.00
64.00	Allowable bad debts (see instructions)		360,001	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		234,001	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		81,413	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		47,869,813	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)		-350,672	70.93
70.94	HRR adjustment amount (see instructions)		-597,567	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/30/2020 2:16 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			504,514	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			46,417,060	71.00
71.01	Sequestration adjustment (see instructions)			928,341	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs				71.03
72.00	Interim payments			45,101,928	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			386,791	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			842,499	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. 1, 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. 11, 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/30/2020 2:16 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		17,158	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		22,317,139	2.00
3.00	OPPS payments		18,602,655	3.00
4.00	Outlier payment (see instructions)		32,992	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)		17,158	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		70,381	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)		70,381	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)		70,381	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		53,223	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)		17,158	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)		18,635,647	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)		3,489,180	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)		15,163,625	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		53,741	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)		15,217,366	30.00
31.00	Primary payer payments		3,633	31.00
32.00	Subtotal (line 30 minus line 31)		15,213,733	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)		520,407	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		338,265	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		318,018	36.00
37.00	Subtotal (see instructions)		15,551,998	37.00
38.00	MSP-LCC reconciliation amount from PS&R		250	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)		15,551,748	40.00
40.01	Sequestration adjustment (see instructions)		311,035	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		15,072,831	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)		167,882	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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/30/2020 2:16 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		815	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		269	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		815	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,339	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)		3,339	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)		3,339	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,524	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)		815	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)		269	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)		1,084	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)		1,084	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,084	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)		1,084	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 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)		1,084	40.00
40.01	Sequestration adjustment (see instructions)		22	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		1,072	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)		-10	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0169

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

Worksheet E-1
Part I
Date/Time Prepared:
6/30/2020 2:16 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		45,101,928		15,072,831	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)		45,101,928		15,072,831	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		386,791		167,882	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		45,488,719		15,240,713	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: 15-0169
Component CCN: 15-S169

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

Worksheet E-1
Part I
Date/Time Prepared:
6/30/2020 2:16 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,393,383		1,072	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)		2,393,383		1,072	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		9,783		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		10	6.02
7.00	Total Medicare program liability (see instructions)		2,403,166		1,062	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/30/2020 2:16 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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 6/30/2020 2:16 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,691,061 1.00
2.00	Net IPF PPS Outlier Payments			625 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)			14.087671 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,691,686 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,691,686 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,691,686 18.00
19.00	Deductibles			205,916 19.00
20.00	Subtotal (line 18 minus line 19)			2,485,770 20.00
21.00	Coinsurance			43,540 21.00
22.00	Subtotal (line 20 minus line 21)			2,442,230 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			15,354 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			9,980 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)			2,452,210 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)			2,452,210 31.00
31.01	Sequestration adjustment (see instructions)			49,044 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,393,383 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)			9,783 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			625 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 6/30/2020 2:16 pm
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Title XVIII		Hospital	PPS
			1.00

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			3.49	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			3.49	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.49	6.00
7.00	Enter the lesser of line 5 or line 6			3.49	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.	1.49	2.00	3.49	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.	1.49	2.00	3.49	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.65		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	1.49	4.65		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.27	4.12		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.42	3.12		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	1.39	3.96		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	1.39	3.96		17.00
18.00	Per resident amount	95,610.28	95,610.28		18.00
19.00	Approved amount for resident costs	132,898	378,617	511,515	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)			511,515	25.00

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	23,533	9,559		26.00
27.00	Total Inpatient Days (see instructions)	82,237	82,237		27.00
28.00	Ratio of inpatient days to total inpatient days	0.286161	0.116237		28.00
29.00	Program direct GME amount	146,376	59,457	205,833	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,162	4,162	30.00
31.00	Net Program direct GME amount			201,671	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 6/30/2020 2:16 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)		4,194,423	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)		61,485,306	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)		14,465	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		61,470,841	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		22,335,112	42.00
43.00	Primary payer payments (see instructions)		3,633	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		22,331,479	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		83,802,320	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.733522	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.266478	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		201,671	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		147,930	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		53,741	50.00

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

Provider CCN: 15-0169

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

Worksheet G

Date/Time Prepared:
6/30/2020 2:16 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	8,600	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,189,246,593	0	0	0	4.00
5.00	Other receivable	-206,080,811	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	587,388	0	0	0	6.00
7.00	Inventory	6,017,967	0	0	0	7.00
8.00	Prepaid expenses	4,364,170	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,994,143,907	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,705,851	0	0	0	12.00
13.00	Land improvements	4,358,832	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	323,581,869	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	4,293,978	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	120,791,132	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	103,991	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-239,815,613	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	316,270	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	216,336,310	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-938,300,419	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-938,300,419	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,272,179,798	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,139,370	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,367,508	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,506,878	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	996,634	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)	996,634	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,503,512	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,265,676,286	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)	1,265,676,286	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,272,179,798	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0169

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

Worksheet G-1

Date/Time Prepared:
6/30/2020 2:16 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		1,153,575,583		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		112,100,703			2.00
3.00	Total (sum of line 1 and line 2)		1,265,676,286		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		1,265,676,286		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,265,676,286		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			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: 15-0169

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
6/30/2020 2:16 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	163,816,637		163,816,637	1.00
2.00	SUBPROVIDER - IPF	11,649,028		11,649,028	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	175,465,665		175,465,665	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	27,406,318		27,406,318	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	92,781,176		92,781,176	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	120,187,494		120,187,494	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	295,653,159		295,653,159	17.00
18.00	Ancillary services	603,787,902	698,819,072	1,302,606,974	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	66,030	66,030	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	899,441,061	698,885,102	1,598,326,163	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		413,824,594		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		413,824,594		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0169

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

Worksheet G-3

Date/Time Prepared:
6/30/2020 2:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,598,326,163	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,077,403,105	2.00
3.00	Net patient revenues (line 1 minus line 2)	520,923,058	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	413,824,594	4.00
5.00	Net income from service to patients (line 3 minus line 4)	107,098,464	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,275,878	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	16,705	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	2,652,289	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	79,419	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	977,949	24.00
25.00	Total other income (sum of lines 6-24)	5,002,240	25.00
26.00	Total (line 5 plus line 25)	112,100,704	26.00
27.00	ROUNDING	1	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	112,100,703	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 6/30/2020 2:16 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,422,108	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		130,826	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)		217.42	3.00
4.00	Number of interns & residents (see instructions)		5.49	4.00
5.00	Indirect medical education percentage (see instructions)		0.71	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)		24,297	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.66	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		30.99	8.00
9.00	Sum of lines 7 and 8		34.65	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.27	10.00
11.00	Disproportionate share adjustment (see instructions)		248,787	11.00
12.00	Total prospective capital payments (see instructions)		3,826,018	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