

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: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---------------------------------------	---

PART I - COST REPORT STATUS

Provider use only

1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.

8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 8/19/2020 Time: 1:53 pm

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 SOUTH (15-0128) 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 OF FINANCE
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	580,007	164,920	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0	0	0		0	6.00
200.00 Total	0	580,007	164,920	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: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/19/2020 1:53 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1402 EAST COUNTY LINE ROAD SOUTH		PO Box:							
2.00	City: INDIANAPOLIS		State: IN		Zip Code: 46227		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	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		COMMUNITY HOSPITAL SOUTH	150128	26900	1	07/01/1966	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2019	12/31/2019		20.00	
21.00	Type of Control (see instructions)					2			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N	22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					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.	1,791	372	3	0	7,316	37			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/19/2020 1:53 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	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.					2	10/01/2019	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/19/2020 1:53 pm	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/19/2020 1:53 pm		
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	2.02	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 MEDICINE	1350	0.00	5.71	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.			N				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0		71.00
75.00	Inpatient Rehabilitation Facility PPS 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)					0		76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/19/2020 1:53 pm		
			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00		
			V 1.00	XIX 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)				106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
			1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/19/2020 1:53 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		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	494,246	0	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	HB0720	140.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 8/19/2020 1:53 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		03/26/2020		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					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: 15-0128

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

Worksheet S-2
Part II
Date/Time Prepared:
8/19/2020 1:53 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been 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		BI SHOP		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: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/19/2020 1:53 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.	NETWORK DIRECTOR OF 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: 15-0128

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

Worksheet S-3
Part I
Date/Time Prepared:
8/19/2020 1:53 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	157	57,305	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)		157	57,305	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		169	61,685	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						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)		169				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: 15-0128

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

Worksheet S-3
Part I
Date/Time Prepared:
8/19/2020 1:53 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)	11,942	1,554	34,871			1.00
2.00 HMO and other (see instructions)	6,162	6,210				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)	11,942	1,554	34,871			7.00
8.00 INTENSIVE CARE UNIT	1,139	0	2,996			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		1,718	2,829			13.00
14.00 Total (see instructions)	13,081	3,272	40,696	7.73	911.33	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						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)			371			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)				7.73	911.33	27.00
28.00 Observation Bed Days		811	5,454			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			593			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	37	633			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: 15-0128

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

Worksheet S-3
Part I
Date/Time Prepared:
8/19/2020 1:53 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	3,222	320	10,060	1.00
2.00 HMO and other (see instructions)				1,340	1,536		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		3,222	320	10,060	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							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: 15-0128

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

Worksheet S-3
Part II
Date/Time Prepared:
8/19/2020 1:53 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	65,210,982	-332,459	64,878,523	1,895,560.00	34.23
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		319,898	0	319,898	1,900.00	168.37
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		260,313	0	260,313	4,160.00	62.58
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)		490,155	0	490,155	17,883.00	27.41
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		607,568	0	607,568	5,805.00	104.66
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		1,486,311	0	1,486,311	16,994.00	87.46
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		20,817,077	0	20,817,077	512,362.00	40.63
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)		16,314,144	0	16,314,144		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		147,289	0	147,289		
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		20,631	0	20,631		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		44,777	0	44,777		
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)		5,049,771	0	5,049,771		
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: 15-0128

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

Worksheet S-3
Part II
Date/Time Prepared:
8/19/2020 1:53 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	2,196	0	2,196	109.00	20.15	26.00
27.00	Administrative & General	4,248,332	-3,481	4,244,851	87,518.00	48.50	27.00
28.00	Administrative & General under contract (see inst.)	4,685,186	0	4,685,186	53,063.00	88.29	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,638,673	-3,831	1,634,842	70,418.00	23.22	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	1,378,711	-3,635	1,375,076	90,630.00	15.17	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,213,364	-851,215	362,149	21,775.00	16.63	34.00
35.00	Dietary under contract (see instructions)	282,261	0	282,261	4,160.00	67.85	35.00
36.00	Cafeteria	0	849,009	849,009	50,739.00	16.73	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	288,151	0	288,151	18,987.00	15.18	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	276,718	-1,519	275,199	6,259.00	43.97	41.00
42.00	Social Service	1,372,074	-3,750	1,368,324	33,465.00	40.89	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3
Part III
Date/Time Prepared:
8/19/2020 1:53 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)	69,918,116	-332,459	69,585,657	1,948,623.00	35.71	1.00
2.00	Excluded area salaries (see instructions)	490,155	0	490,155	17,883.00	27.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)	69,427,961	-332,459	69,095,502	1,930,740.00	35.79	3.00
4.00	Subtotal other wages & related costs (see inst.)	22,910,956	0	22,910,956	535,161.00	42.81	4.00
5.00	Subtotal wage-related costs (see inst.)	21,384,546	0	21,384,546	0.00	30.95	5.00
6.00	Total (sum of lines 3 thru 5)	113,723,463	-332,459	113,391,004	2,465,901.00	45.98	6.00
7.00	Total overhead cost (see instructions)	15,385,666	-18,422	15,367,244	437,123.00	35.16	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 8/19/2020 1:53 pm
-----------------------------	-----------------------	---	--

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,248,155	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)	7,866	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	616,145	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)	6,499,614	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,664,565	9.00
10.00	Dental, Hearing and Vision Plan	64,708	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	36,559	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)	510,106	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	141,431	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,648,594	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	89,099	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	16,526,842	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: 15-0128

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

Worksheet S-3
Part V
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	607,568	16,526,842	1.00
2.00	Hospital	607,568	16,379,553	2.00
3.00	Subprovider - IPF			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	147,289	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/19/2020 1:53 pm
---	-----------------------	---	--

			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.200040	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		47,527,786	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		155,494,777	6.00	
7.00	Medicaid cost (line 1 times line 6)		31,105,175	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)	21,490,836	2,551,564	24,042,400	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,299,027	2,551,564	6,850,591	21.00
22.00	Payments received from patients for amounts previously written off as charity care	880	25	905	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,298,147	2,551,539	6,849,686	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		21,441,612	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		486,353	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		748,236	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		20,693,376	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,401,386	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		11,251,072	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		11,251,072	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet A	
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	10,458,853	10,458,853	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	6,658,970	6,658,970	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,196	9,417	11,613	-25	11,588	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,248,332	89,516,335	93,764,667	-9,629,677	84,134,990	5.00
7.00	00700	OPERATION OF PLANT	1,638,673	4,382,738	6,021,411	-92,196	5,929,215	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	673,742	673,742	0	673,742	8.00
9.00	00900	HOUSEKEEPING	1,378,711	1,027,804	2,406,515	-13,843	2,392,672	9.00
10.00	01000	DIETARY	1,213,364	1,760,277	2,973,641	-2,103,808	869,833	10.00
11.00	01100	CAFETERIA	0	0	0	2,027,785	2,027,785	11.00
13.00	01300	NURSING ADMINISTRATION	288,151	74,391	362,542	0	362,542	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	276,718	87,638	364,356	-80	364,276	16.00
17.00	01700	SOCIAL SERVICE	1,372,074	347,407	1,719,481	-2,403	1,717,078	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,717,672	9,500,762	32,218,434	-5,643,569	26,574,865	30.00
31.00	03100	INTENSIVE CARE UNIT	2,841,571	1,325,309	4,166,880	-429,862	3,737,018	31.00
43.00	04300	NURSERY	0	0	0	674,855	674,855	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,561,854	18,371,851	21,933,705	-15,195,180	6,738,525	50.00
51.00	05100	RECOVERY ROOM	2,894,582	1,292,395	4,186,977	-253,246	3,933,731	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	605,229	35,036	640,265	3,235,339	3,875,604	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,940,105	1,979,850	3,919,955	-1,231,673	2,688,282	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	619,700	1,533,918	2,153,618	-1,093,976	1,059,642	55.00
57.00	05700	CT SCAN	718,900	1,101,114	1,820,014	-389,891	1,430,123	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	311,938	208,345	520,283	-18,779	501,504	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,476,947	8,456,453	9,933,400	-7,043,337	2,890,063	59.00
60.00	06000	LABORATORY	0	7,422,470	7,422,470	-2,284	7,420,186	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,830,848	1,029,741	2,860,589	-385,158	2,475,431	65.00
66.00	06600	PHYSICAL THERAPY	2,794,566	1,378,109	4,172,675	-1,456,660	2,716,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	740,187	740,187	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	170,711	170,711	68.00
69.00	06900	ELECTROCARDIOLOGY	873,213	516,226	1,389,439	-101,124	1,288,315	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	476,083	376,473	852,556	-55,986	796,570	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	982,249	982,249	12,677,203	13,659,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,334,651	10,334,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,916,927	8,883,034	11,799,961	-96,468	11,703,493	73.00
74.00	07400	RENAL DIALYSIS	0	466,743	466,743	-3,934	462,809	74.00
76.00	03950	ENDOSCOPY	642,866	1,243,277	1,886,143	-826,758	1,059,385	76.00
76.06	03330	IMAGING CENTER	866,596	1,037,690	1,904,286	-442,635	1,461,651	76.06
76.97	07697	CARDIAC REHABILITATION	282,394	102,543	384,937	-17,451	367,486	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	506,389	174,345	680,734	-15,801	664,933	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPIRE CENTER	125,168	137,558	262,726	-68,458	194,268	90.04
91.00	09100	EMERGENCY	5,299,060	2,822,219	8,121,279	-355,479	7,765,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,720,827	168,257,459	232,978,286	8,813	232,987,099	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	319	192,615	192,934	0	192,934	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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	489,836	341,289	831,125	-8,813	822,312	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	65,210,982	168,791,363	234,002,345	0	234,002,345	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

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

Worksheet A
Date/Time Prepared:
8/19/2020 1:53 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	-3,167,505	7,291,348	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,532,060	10,191,030	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,721,137	2,732,725	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-44,286,252	39,848,738	5.00
7.00	00700	OPERATION OF PLANT	-353,919	5,575,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	673,742	8.00
9.00	00900	HOUSEKEEPING	0	2,392,672	9.00
10.00	01000	DIETARY	-38,901	830,932	10.00
11.00	01100	CAFETERIA	-1,465,834	561,951	11.00
13.00	01300	NURSING ADMINISTRATION	2,736,136	3,098,678	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,684,384	2,048,660	16.00
17.00	01700	SOCIAL SERVICE	0	1,717,078	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	608,162	608,162	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	808,192	808,192	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,732,438	28,307,303	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,737,018	31.00
43.00	04300	NURSERY	0	674,855	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,738,525	50.00
51.00	05100	RECOVERY ROOM	0	3,933,731	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,875,604	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-185,775	2,502,507	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,059,642	55.00
57.00	05700	CT SCAN	0	1,430,123	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	501,504	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,890,063	59.00
60.00	06000	LABORATORY	-829,984	6,590,202	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,475,431	65.00
66.00	06600	PHYSICAL THERAPY	-19,037	2,696,978	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	740,187	67.00
68.00	06800	SPEECH PATHOLOGY	0	170,711	68.00
69.00	06900	ELECTROCARDIOLOGY	51,166	1,339,481	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113,313	909,883	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	831,225	14,490,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,334,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	220,537	11,924,030	73.00
74.00	07400	RENAL DIALYSIS	0	462,809	74.00
76.00	03950	ENDOSCOPY	0	1,059,385	76.00
76.06	03330	IMAGING CENTER	0	1,461,651	76.06
76.97	07697	CARDIAC REHABILITATION	-9,351	358,135	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	-323,865	341,068	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	194,268	90.04
91.00	09100	EMERGENCY	0	7,765,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-35,641,673	197,345,426	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	192,934	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	822,312	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-35,641,673	198,360,672	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - Chargeable Medical Supplies						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,907,107		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
TOTALS			0	13,907,107		
B - Implantable Device Recl ass						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,334,651		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
TOTALS			0	10,334,651		
C - Drugs Charges to Pat						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		457		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00		443,141		2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00						16.00
17.00						17.00
18.00						18.00
19.00						19.00
20.00			0	443,598		20.00
D - Depreciation Expense						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,220,661		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

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
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
TOTALS			0	9,220,661	
E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,565,108	1.00
TOTALS			0	5,565,108	
F - Other Capital Rental					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,203,193	1.00
2.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	1,279	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
TOTALS			0	2,204,472	
G - STD BENEFIT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,481	1.00
2.00	OPERATION OF PLANT	7.00	0	3,831	2.00
3.00	HOUSEKEEPING	9.00	0	3,635	3.00
4.00	DIETARY	10.00	0	2,206	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,519	5.00
6.00	SOCIAL SERVICE	17.00	0	3,750	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	145,086	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	23,340	8.00
9.00	OPERATING ROOM	50.00	0	4,310	9.00
10.00	RECOVERY ROOM	51.00	0	21,615	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,280	11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	4,403	12.00
13.00	RESPIRATORY THERAPY	65.00	0	9,627	13.00
14.00	PHYSICAL THERAPY	66.00	0	25,812	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	6,079	15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,225	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	35,169	17.00
18.00	ENDOSCOPY	76.00	0	403	18.00
19.00	IMAGING CENTER	76.06	0	3,216	19.00
20.00	CARDIAC REHABILITATION	76.97	0	594	20.00
21.00	ANTI-COAGULATION CLINIC	90.02	0	2,670	21.00
22.00	EMERGENCY	91.00	0	28,208	22.00
TOTALS			0	332,459	

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
H - Labor and Delivery					
1.00	NURSERY	43.00	484,125	190,730	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,320,957	914,382	2.00
	TOTALS		2,805,082	1,105,112	
I - Cafeteria					
1.00	CAFETERIA	11.00	849,009	1,178,776	1.00
	TOTALS		849,009	1,178,776	
J - Therapy					
1.00	OCCUPATIONAL THERAPY	67.00	563,360	176,827	1.00
2.00	SPEECH PATHOLOGY	68.00	129,929	40,782	2.00
	TOTALS		693,289	217,609	
K - Building Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,764,884	1.00
	TOTALS		0	4,764,884	
L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	128,861	1.00
	TOTALS		0	128,861	
M - Radiology Support Staff					
1.00	RADIOLOGY-THERAPEUTIC	55.00	56,234	29,612	1.00
2.00	CT SCAN	57.00	154,940	81,590	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	27,795	14,636	3.00
	TOTALS		238,969	125,838	
500.00	Grand Total: Increases		4,586,349	49,529,136	500.00

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6
Date/Time Prepared:
8/19/2020 1:53 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	14,352	0	1.00	
2.00	OPERATION OF PLANT	7.00	0	16	0	2.00	
3.00	DIETARY	10.00	0	395	0	3.00	
4.00	SOCIAL SERVICE	17.00	0	22	0	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	1,246,305	0	5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	232,132	0	6.00	
7.00	OPERATING ROOM	50.00	0	6,500,845	0	7.00	
8.00	RECOVERY ROOM	51.00	0	212,477	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	498,215	0	9.00	
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	714,379	0	10.00	
11.00	CT SCAN	57.00	0	171,631	0	11.00	
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10,792	0	12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	2,743,817	0	13.00	
14.00	LABORATORY	60.00	0	31	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	353,870	0	15.00	
16.00	PHYSICAL THERAPY	66.00	0	43,816	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	13,605	0	17.00	
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	19,860	0	18.00	
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	121,993	0	19.00	
20.00	RENAL DIALYSIS	74.00	0	3,276	0	20.00	
21.00	ENDOSCOPY	76.00	0	494,544	0	21.00	
22.00	IMAGING CENTER	76.06	0	246,649	0	22.00	
23.00	CARDIAC REHABILITATION	76.97	0	8,839	0	23.00	
24.00	ANTI-COAGULATION CLINIC	90.02	0	392	0	24.00	
25.00	SPINE CENTER	90.04	0	72	0	25.00	
26.00	EMERGENCY	91.00	0	248,988	0	26.00	
27.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	5,794	0	27.00	
TOTALS			0	13,907,107			
B - Implantable Device Recl							
1.00	OPERATING ROOM	50.00	0	6,871,439	0	1.00	
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	200,744	0	2.00	
3.00	CARDIAC CATHETERIZATION	59.00	0	3,261,771	0	3.00	
4.00	ENDOSCOPY	76.00	0	697	0	4.00	
TOTALS			0	10,334,651			
C - Drugs Charges to Pat							
1.00	OPERATION OF PLANT	7.00		25		1.00	
2.00	ADULTS & PEDIATRICS	30.00		53,065		2.00	
3.00	INTENSIVE CARE UNIT	31.00		8,560		3.00	
4.00	OPERATING ROOM	50.00		4,471		4.00	
5.00	RECOVERY ROOM	51.00		9,159		5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00		59,404		6.00	
7.00	RADIOLOGY-THERAPEUTIC	55.00		2,866		7.00	
8.00	CT SCAN	57.00		179,248		8.00	
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		1,332		9.00	
10.00	CARDIAC CATHETERIZATION	59.00		81,657		10.00	
11.00	RESPIRATORY THERAPY	65.00		1,798		11.00	
12.00	PHYSICAL THERAPY	66.00		993		12.00	
13.00	ELECTROCARDIOLOGY	69.00		237		13.00	
14.00	ELECTROENCEPHALOGRAPHY	70.00		397		14.00	
15.00	RENAL DIALYSIS	74.00		554		15.00	
16.00	ENDOSCOPY	76.00		895		16.00	
17.00	IMAGING CENTER	76.06		19,909		17.00	
18.00	CARDIAC REHABILITATION	76.97		57		18.00	
19.00	ANTI-COAGULATION CLINIC	90.02		11		19.00	
20.00	EMERGENCY	91.00		18,960		20.00	
TOTALS			0	443,598			
D - Depreciation Expense							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,920,144	9	1.00	
2.00	OPERATION OF PLANT	7.00	0	86,236	0	2.00	
3.00	HOUSEKEEPING	9.00	0	5,174	0	3.00	
4.00	DIETARY	10.00	0	71,610	0	4.00	
5.00	SOCIAL SERVICE	17.00	0	1,805	0	5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	418,377	0	6.00	
7.00	INTENSIVE CARE UNIT	31.00	0	189,170	0	7.00	
8.00	OPERATING ROOM	50.00	0	1,636,105	0	8.00	
9.00	RECOVERY ROOM	51.00	0	26,955	0	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	308,488	0	10.00	
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	261,446	0	11.00	
12.00	CT SCAN	57.00	0	275,542	0	12.00	

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6
Date/Time Prepared:
8/19/2020 1:53 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	49,086	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	953,849	0	14.00
15.00	LABORATORY	60.00	0	2,173	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	27,775	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	139,324	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	86,864	0	18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	22,995	0	19.00
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	34,727	0	20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	67,533	0	21.00
22.00	ENDOSCOPY	76.00	0	329,858	0	22.00
23.00	IMAGING CENTER	76.06	0	175,654	0	23.00
24.00	CARDIAC REHABILITATION	76.97	0	8,555	0	24.00
25.00	ANTI-COAGULATION CLINIC	90.02	0	15,385	0	25.00
26.00	SPINE CENTER	90.04	0	14,082	0	26.00
27.00	EMERGENCY	91.00	0	87,451	0	27.00
28.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	4,298	0	28.00
	TOTALS		0	9,220,661		
E - Interest Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,565,108	11	1.00
	TOTALS		0	5,565,108		
F - Other Capital Rental						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	25	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,212	0	2.00
3.00	OPERATION OF PLANT	7.00	0	5,919	0	3.00
4.00	HOUSEKEEPING	9.00	0	8,669	0	4.00
5.00	DIETARY	10.00	0	4,018	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	80	0	6.00
7.00	SOCIAL SERVICE	17.00	0	576	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	15,628	0	8.00
9.00	OPERATING ROOM	50.00	0	182,320	0	9.00
10.00	RECOVERY ROOM	51.00	0	4,655	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	759	0	11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	387	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	2,243	0	13.00
14.00	LABORATORY	60.00	0	80	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	1,715	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	361,629	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	418	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	12,734	0	18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,195,634	0	19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	350,083	0	20.00
21.00	RENAL DIALYSIS	74.00	0	104	0	21.00
22.00	ENDOSCOPY	76.00	0	764	0	22.00
23.00	IMAGING CENTER	76.06	0	423	0	23.00
24.00	ANTI-COAGULATION CLINIC	90.02	0	13	0	24.00
25.00	SPINE CENTER	90.04	0	54,304	0	25.00
26.00	EMERGENCY	91.00	0	80	0	26.00
	TOTALS		0	2,204,472		
G - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,481	0	0	1.00
2.00	OPERATION OF PLANT	7.00	3,831	0	0	2.00
3.00	HOUSEKEEPING	9.00	3,635	0	0	3.00
4.00	DIETARY	10.00	2,206	0	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	1,519	0	0	5.00
6.00	SOCIAL SERVICE	17.00	3,750	0	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	145,086	0	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	23,340	0	0	8.00
9.00	OPERATING ROOM	50.00	4,310	0	0	9.00
10.00	RECOVERY ROOM	51.00	21,615	0	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	1,280	0	0	11.00
12.00	CARDIAC CATHETERIZATION	59.00	4,403	0	0	12.00
13.00	RESPIRATORY THERAPY	65.00	9,627	0	0	13.00
14.00	PHYSICAL THERAPY	66.00	25,812	0	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	6,079	0	0	15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	2,225	0	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	35,169	0	0	17.00
18.00	ENDOSCOPY	76.00	403	0	0	18.00
19.00	IMAGING CENTER	76.06	3,216	0	0	19.00
20.00	CARDIAC REHABILITATION	76.97	594	0	0	20.00
21.00	ANTI-COAGULATION CLINIC	90.02	2,670	0	0	21.00

Decreases							
	Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00		
22.00	EMERGENCY	91.00	28,208	0	0	0	22.00
	TOTALS		332,459	0			
H - Labor and Delivery							
1.00	ADULTS & PEDIATRICS	30.00	2,805,082	1,105,112		0	1.00
2.00		0.00	0	0		0	2.00
	TOTALS		2,805,082	1,105,112			
I - Cafeteria							
1.00	DIETARY	10.00	849,009	1,178,776		0	1.00
	TOTALS		849,009	1,178,776			
J - Therapy							
1.00	PHYSICAL THERAPY	66.00	693,289	217,609		0	1.00
2.00		0.00	0	0		0	2.00
	TOTALS		693,289	217,609			
K - Building Depreciation							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,764,884		9	1.00
	TOTALS		0	4,764,884			
L - Capital Insurance Costs							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	128,861		12	1.00
	TOTALS		0	128,861			
M - Radiology Support Staff							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	238,969	125,838		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
	TOTALS		238,969	125,838			
500.00	Grand Total: Decreases		4,918,808	49,196,677			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7
Part I
Date/Time Prepared:
8/19/2020 1:53 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,254,312	0	0	0	1.00
2.00	Land Improvements	2,722,362	0	0	0	2.00
3.00	Buildings and Fixtures	177,055,544	19,253,731	0	19,253,731	3.00
4.00	Building Improvements	1,737,035	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	76,878,740	5,687,903	0	5,687,903	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	259,647,993	24,941,634	0	24,941,634	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	259,647,993	24,941,634	0	24,941,634	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,254,312	0			1.00
2.00	Land Improvements	2,722,362	0			2.00
3.00	Buildings and Fixtures	183,134,844	0			3.00
4.00	Building Improvements	1,737,035	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	82,595,663	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	271,444,216	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	271,444,216	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7
Part II
Date/Time Prepared:
8/19/2020 1:53 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: 15-0128

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

Worksheet A-7
Part III
Date/Time Prepared:
8/19/2020 1:53 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	188,848,552	0	188,848,552	0.695867	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	82,537,623	0	82,537,623	0.304133	0	2.00
3.00	Total (sum of lines 1-2)	271,386,175	0	271,386,175	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,764,884	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,987,837	2,203,193	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,752,721	2,203,193	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	2,397,603	128,861	0	0	7,291,348	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	10,191,030	2.00
3.00	Total (sum of lines 1-2)	2,397,603	128,861	0	0	17,482,378	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

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

Worksheet A-8

Date/Time Prepared:
8/19/2020 1:53 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
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	-11,797		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	-234,476				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,654,944				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,357,812		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)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
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: 15-0128

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

Worksheet A-8

Date/Time Prepared:
8/19/2020 1:53 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		
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.00
33.01 Misc Revenue	B	-13,762	OPERATION OF PLANT	7.00		0 33.01
33.02 Misc Revenue	B	-38,901	DIETARY	10.00		0 33.02
33.03 Misc Revenue	B	-227,792	RADIOLOGY-DIAGNOSTIC	54.00		0 33.03
33.04 Misc Revenue	B	-663	LABORATORY	60.00		0 33.04
33.05 Misc Revenue	B	-19,037	PHYSICAL THERAPY	66.00		0 33.05
33.06 Misc Revenue	B	-8,224	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		0 33.06
33.07 Misc Revenue	B	-46,800	DRUGS CHARGED TO PATIENTS	73.00		0 33.07
33.08 Misc Revenue	B	-9,351	CARDIAC REHABILITATION	76.97		0 33.08
33.09 Space Rental Income	B	-49,749	ADMINISTRATIVE & GENERAL	5.00		0 33.09
33.10 Space Rental Income	B	-747,893	OPERATION OF PLANT	7.00		0 33.10
33.11 Investment Income	B	-829,321	LABORATORY	60.00		0 33.11
34.00 HAF Tax Offset	A	-14,349,243	ADMINISTRATIVE & GENERAL	5.00		0 34.00
34.01 LOC Non-Allow Interest Expense	A	-36,638	CAP REL COSTS-BLDG & FIXT	1.00		11 34.01
34.02 Non-Allowable Interest Expense 00	A	-921,968	CAP REL COSTS-BLDG & FIXT	1.00		11 34.02
34.03 2012B Non-Allow Interest Expense	A	-96,191	CAP REL COSTS-BLDG & FIXT	1.00		11 34.03
34.04 50M BMO Non-Allow Interest Expense	A	-32,067	CAP REL COSTS-BLDG & FIXT	1.00		11 34.04
34.05 12B Non-Allow Interest Expense	A	-392,391	CAP REL COSTS-BLDG & FIXT	1.00		11 34.05
34.06 50 BMO Loan Non-Allow Interest Expense	A	31,769	CAP REL COSTS-BLDG & FIXT	1.00		11 34.06
34.07 Non-Allowable Interest Expense 00	A	-1,720,019	CAP REL COSTS-BLDG & FIXT	1.00		11 34.07
35.00 Bad Debt	A	-16,752,404	ADMINISTRATIVE & GENERAL	5.00		0 35.00
36.00 Meals of Wheels Cost	A	-108,022	CAFETERIA	11.00		0 36.00
36.01 Nurse Practitioner Offset	A	-323,865	ANTI-COAGULATION CLINIC	90.02		0 36.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-35,641,673				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: 15-0128
 Period: From 01/01/2019 To 12/31/2019
 Worksheet A-8-1
 Date/Time Prepared: 8/19/2020 1:53 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	5.00	ADMINISTRATIVE & GENERAL	1550 COUNTY LN RD	89,772	67,057	1.00
2.00	30.00	ADULTS & PEDIATRICS	1550 COUNTY LN RD	52,772	39,420	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	3,532,060	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,721,137	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	32,250,536	45,251,762	3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE	407,736	0	3.03
3.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	2,736,136	0	3.04
3.05	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1,684,384	0	3.05
3.06	30.00	ADULTS & PEDIATRICS	HOME OFFICE	437,348	0	3.06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	1,281,738	0	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	42,017	0	3.08
3.09	69.00	ELECTROCARDIOLOGY	HOME OFFICE	51,166	0	3.09
3.10	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	113,313	0	3.10
3.11	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	839,449	0	3.11
3.12	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	267,337	0	3.12
4.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	608,162	0	4.00
4.01	22.00	I&R SERVICES-OTHER PRGM. COS	INTERNS & RESIDENTS	808,192	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR AND CAL	89,928	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			48,013,183	45,358,239	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	C	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:	OTHER			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: 15-0128

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

Worksheet A-8-1

Date/Time Prepared:
8/19/2020 1:53 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	22,715	0		1.00
2.00	13,352	0		2.00
3.00	3,532,060	9		3.00
3.01	2,721,137	0		3.01
3.02	-13,001,226	0		3.02
3.03	407,736	0		3.03
3.04	2,736,136	0		3.04
3.05	1,684,384	0		3.05
3.06	437,348	0		3.06
3.07	1,281,738	0		3.07
3.08	42,017	0		3.08
3.09	51,166	0		3.09
3.10	113,313	0		3.10
3.11	839,449	0		3.11
3.12	267,337	0		3.12
4.00	608,162	0		4.00
4.01	808,192	0		4.01
4.02	89,928	0		4.02
5.00	2,654,944			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: 15-0128

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

Worksheet A-8-2

Date/Time Prepared:
8/19/2020 1:53 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	444,349	96,568	347,781	211,500	2,064	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			444,349	96,568	347,781		2,064	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	209,873	10,494	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			209,873	10,494	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	209,873	137,908	234,476		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	209,873	137,908	234,476		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B
Part I
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,291,348	7,291,348			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	10,191,030		10,191,030		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,732,725	0	25	2,732,750	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	39,848,738	410,760	3,927,269	178,802	44,365,569
7.00 00700	OPERATION OF PLANT	5,575,296	1,370,457	45,391	68,863	7,060,007
8.00 00800	LAUNDRY & LINEN SERVICE	673,742	19,882	0	0	693,624
9.00 00900	HOUSEKEEPING	2,392,672	42,693	13,666	57,921	2,506,952
10.00 01000	DIETARY	830,932	71,252	27,199	15,254	944,637
11.00 01100	CAFETERIA	561,951	166,025	44,893	35,762	808,631
13.00 01300	NURSING ADMINISTRATION	3,098,678	0	0	12,137	3,110,815
16.00 01600	MEDICAL RECORDS & LIBRARY	2,048,660	0	79	11,592	2,060,331
17.00 01700	SOCIAL SERVICE	1,717,078	19,973	2,351	57,637	1,797,039
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	608,162	0	0	0	608,162
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	808,192	11,733	0	0	819,925
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	28,307,303	1,815,959	210,588	832,677	31,166,527
31.00 03100	INTENSIVE CARE UNIT	3,737,018	551,410	186,753	118,710	4,593,891
43.00 04300	NURSERY	674,855	49,606	9,287	20,392	754,140
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,738,525	661,299	1,160,178	149,851	8,709,853
51.00 05100	RECOVERY ROOM	3,933,731	154,692	30,715	121,015	4,240,153
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,875,604	237,805	44,520	123,257	4,281,186
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,502,507	222,925	272,177	71,655	3,069,264
55.00 05500	RADIOLOGY-THERAPEUTIC	1,059,642	0	256,765	28,418	1,344,825
57.00 05700	CT SCAN	1,430,123	27,377	254,361	36,808	1,748,669
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	501,504	30,633	17,001	14,310	563,448
59.00 05900	CARDIAC CATHETERIZATION	2,890,063	201,733	724,403	62,026	3,878,225
60.00 06000	LABORATORY	6,590,202	93,645	79	0	6,683,926
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,475,431	46,786	27,157	76,713	2,626,087
66.00 06600	PHYSICAL THERAPY	2,696,978	16,190	597,974	87,423	3,398,565
67.00 06700	OCCUPATIONAL THERAPY	740,187	4,348	27,728	23,730	795,993
68.00 06800	SPEECH PATHOLOGY	170,711	1,000	6,395	5,473	183,579
69.00 06900	ELECTROCARDIOLOGY	1,339,481	113,509	58,278	36,525	1,547,793
70.00 07000	ELECTROENCEPHALOGRAPHY	909,883	45,513	35,273	19,960	1,010,629
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,490,677	211,865	1,214,617	0	15,917,159
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	10,334,651	0	0	0	10,334,651
73.00 07300	DRUGS CHARGED TO PATIENTS	11,924,030	115,201	389,186	121,385	12,549,802
74.00 07400	RENAL DIALYSIS	462,809	22,047	103	0	484,959
76.00 03950	ENDOSCOPY	1,059,385	0	284,566	27,062	1,371,013
76.06 03330	IMAGING CENTER	1,461,651	0	173,827	36,367	1,671,845
76.97 07697	CARDIAC REHABILITATION	358,135	0	6,739	11,870	376,744
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02 04951	ANTI-COAGULATION CLINIC	341,068	0	2,168	21,218	364,454
90.03 04952	PALLIATIVE CARE	0	0	0	0	0
90.04 04953	SPIRE CENTER	194,268	0	67,428	5,272	266,968
91.00 09100	EMERGENCY	7,765,800	544,352	68,911	222,019	8,601,082
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	197,345,426	7,280,670	10,188,050	2,712,104	197,311,122
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	192,934	0	0	13	192,947
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	HOME OFFICE	0	0	0	0	0
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	822,312	10,678	2,980	20,633	856,603
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	198,360,672	7,291,348	10,191,030	2,732,750	198,360,672

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B
Part I
Date/Time Prepared:
8/19/2020 1:53 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	44,365,569				5.00
7.00	00700	OPERATION OF PLANT	2,033,967	9,093,974			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	199,831	32,814	926,269		8.00
9.00	00900	HOUSEKEEPING	722,245	70,461	0	3,299,658	9.00
10.00	01000	DIETARY	272,147	117,596	0	43,158	1,377,538
11.00	01100	CAFETERIA	232,964	274,009	0	100,564	0
13.00	01300	NURSING ADMINISTRATION	896,216	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	593,575	0	0	0	0
17.00	01700	SOCIAL SERVICE	517,722	32,964	0	12,098	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	175,210	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	236,218	19,364	0	7,107	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,979,024	2,997,081	423,089	1,099,951	1,261,595
31.00	03100	INTENSIVE CARE UNIT	1,323,486	910,052	54,234	333,996	115,943
43.00	04300	NURSERY	217,265	81,870	9,940	30,047	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,509,283	1,091,414	0	400,558	0
51.00	05100	RECOVERY ROOM	1,221,575	255,306	139,608	93,699	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,233,397	392,475	47,642	144,042	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	884,246	367,918	16,911	135,029	0
55.00	05500	RADIOLOGY-THERAPEUTIC	387,440	0	0	0	0
57.00	05700	CT SCAN	503,786	45,183	50,693	16,582	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	162,328	50,557	0	18,555	0
59.00	05900	CARDIAC CATHETERIZATION	1,117,305	332,942	10,862	122,192	0
60.00	06000	LABORATORY	1,925,619	154,552	0	56,722	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	756,568	77,216	0	28,339	0
66.00	06600	PHYSICAL THERAPY	979,116	26,719	0	9,806	0
67.00	06700	OCCUPATIONAL THERAPY	229,323	7,175	0	2,633	0
68.00	06800	SPEECH PATHOLOGY	52,889	1,651	0	606	0
69.00	06900	ELECTROCARDIOLOGY	445,915	187,336	0	68,754	0
70.00	07000	ELECTROENCEPHALOGRAPHY	291,159	75,115	0	27,568	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,585,686	349,664	0	128,330	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,977,382	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,615,560	190,128	0	69,779	0
74.00	07400	RENAL DIALYSIS	139,715	36,386	0	13,354	0
76.00	03950	ENDOSCOPY	394,985	0	0	0	0
76.06	03330	IMAGING CENTER	481,654	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	108,539	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	104,998	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	76,913	0	0	0	0
91.00	09100	EMERGENCY	2,477,946	898,403	173,290	329,721	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,063,197	9,076,351	926,269	3,293,190	1,377,538
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,587	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	246,785	17,623	0	6,468	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	44,365,569	9,093,974	926,269	3,299,658	1,377,538

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B
Part I
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
					SERVICES-SALARY & FRINGES		
	11.00	13.00	16.00	17.00	21.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00 00500 ADMINISTRATIVE & GENERAL						5.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA	1,416,168					11.00	
13.00 01300 NURSING ADMINISTRATION	17,826	4,024,857				13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	5,942	0	2,659,848			16.00	
17.00 01700 SOCIAL SERVICE	31,690	0	0	2,391,513		17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	783,372	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	554,582	2,867,583	317,792	2,049,205	610,080	30.00	
31.00 03100 INTENSIVE CARE UNIT	59,420	307,241	30,931	176,061	25,533	31.00	
43.00 04300 NURSERY	11,884	61,448	10,725	166,247	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	102,994	0	312,184	0	33,848	50.00	
51.00 05100 RECOVERY ROOM	65,362	0	105,403	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	61,400	0	51,417	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	45,555	0	94,081	0	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	17,826	0	57,503	0	0	55.00	
57.00 05700 CT SCAN	23,768	0	175,137	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	7,923	0	31,547	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	35,652	0	218,104	0	0	59.00	
60.00 06000 LABORATORY	0	0	220,118	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	47,536	0	36,533	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	21,787	0	32,717	0	12,630	66.00	
67.00 06700 OCCUPATIONAL THERAPY	13,865	0	9,100	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	3,961	0	2,098	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	33,671	0	75,889	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	11,884	0	13,304	0	8,325	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	124,743	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	93,437	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	63,381	0	183,368	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	4,016	0	0	74.00	
76.00 03950 ENDOSCOPY	13,865	0	33,442	0	0	76.00	
76.06 03330 IMAGING CENTER	1,981	0	39,798	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	9,903	0	4,765	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	0	2,979	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	0	784	0	0	90.04	
91.00 09100 EMERGENCY	152,510	788,585	377,933	0	68,264	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,416,168	4,024,857	2,659,848	2,391,513	758,680	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	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 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	24,692	194.08	
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,416,168	4,024,857	2,659,848	2,391,513	783,372	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B
Part I
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	SERVICES-OTHER PRGM. COSTS					
	22.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00 00500	ADMINISTRATIVE & GENERAL				5.00	
7.00 00700	OPERATION OF PLANT				7.00	
8.00 00800	LAUNDRY & LINEN SERVICE				8.00	
9.00 00900	HOUSEKEEPING				9.00	
10.00 01000	DIETARY				10.00	
11.00 01100	CAFETERIA				11.00	
13.00 01300	NURSING ADMINISTRATION				13.00	
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00 01700	SOCIAL SERVICE				17.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00	
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,082,614			22.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	843,124	53,169,633	-1,453,204	51,716,429	30.00
31.00 03100	INTENSIVE CARE UNIT	35,287	7,966,075	-60,820	7,905,255	31.00
43.00 04300	NURSERY	0	1,343,566	0	1,343,566	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	46,778	13,206,912	-80,626	13,126,286	50.00
51.00 05100	RECOVERY ROOM	0	6,121,106	0	6,121,106	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	6,211,559	0	6,211,559	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	4,613,004	0	4,613,004	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	1,807,594	0	1,807,594	55.00
57.00 05700	CT SCAN	0	2,563,818	0	2,563,818	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	834,358	0	834,358	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	5,715,282	0	5,715,282	59.00
60.00 06000	LABORATORY	0	9,040,937	0	9,040,937	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	3,572,279	0	3,572,279	65.00
66.00 06600	PHYSICAL THERAPY	17,454	4,498,794	-30,084	4,468,710	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,058,089	0	1,058,089	67.00
68.00 06800	SPEECH PATHOLOGY	0	244,784	0	244,784	68.00
69.00 06900	ELECTROCARDIOLOGY	0	2,359,358	0	2,359,358	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	11,506	1,449,490	-19,831	1,429,659	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,105,582	0	21,105,582	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,405,470	0	13,405,470	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	16,672,018	0	16,672,018	73.00
74.00 07400	RENAL DIALYSIS	0	678,430	0	678,430	74.00
76.00 03950	ENDOSCOPY	0	1,813,305	0	1,813,305	76.00
76.06 03330	IMAGING CENTER	0	2,195,278	0	2,195,278	76.06
76.97 07697	CARDIAC REHABILITATION	0	499,951	0	499,951	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	472,431	0	472,431	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPIRE CENTER	0	344,665	0	344,665	90.04
91.00 09100	EMERGENCY	94,340	13,962,074	-162,604	13,799,470	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,048,489	196,925,842	-1,807,169	195,118,673	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	248,534	0	248,534	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	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	34,125	1,186,296	-58,817	1,127,479	194.08
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,082,614	198,360,672	-1,865,986	196,494,686	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 8/19/2020 1:53 pm
-------------------------------------	--	-----------------------	---	--

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	0	25	25	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	410,760	3,927,269	4,338,029	5.00
7.00 00700	OPERATION OF PLANT	0	1,370,457	45,391	1,415,848	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	19,882	0	19,882	8.00
9.00 00900	HOUSEKEEPING	0	42,693	13,666	56,359	9.00
10.00 01000	DIETARY	0	71,252	27,199	98,451	10.00
11.00 01100	CAFETERIA	0	166,025	44,893	210,918	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	79	79	16.00
17.00 01700	SOCIAL SERVICE	0	19,973	2,351	22,324	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	11,733	0	11,733	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,815,959	210,588	2,026,547	30.00
31.00 03100	INTENSIVE CARE UNIT	0	551,410	186,753	738,163	31.00
43.00 04300	NURSERY	0	49,606	9,287	58,893	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	661,299	1,160,178	1,821,477	50.00
51.00 05100	RECOVERY ROOM	0	154,692	30,715	185,407	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	237,805	44,520	282,325	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	222,925	272,177	495,102	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	256,765	256,765	55.00
57.00 05700	CT SCAN	0	27,377	254,361	281,738	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	30,633	17,001	47,634	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	201,733	724,403	926,136	59.00
60.00 06000	LABORATORY	0	93,645	79	93,724	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	46,786	27,157	73,943	65.00
66.00 06600	PHYSICAL THERAPY	0	16,190	597,974	614,164	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,348	27,728	32,076	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,000	6,395	7,395	68.00
69.00 06900	ELECTROCARDIOLOGY	0	113,509	58,278	171,787	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	45,513	35,273	80,786	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	211,865	1,214,617	1,426,482	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	115,201	389,186	504,387	73.00
74.00 07400	RENAL DIALYSIS	0	22,047	103	22,150	74.00
76.00 03950	ENDOSCOPY	0	0	284,566	284,566	76.00
76.06 03330	IMAGING CENTER	0	0	173,827	173,827	76.06
76.97 07697	CARDIAC REHABILITATION	0	0	6,739	6,739	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	0	2,168	2,168	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	0	67,428	67,428	90.04
91.00 09100	EMERGENCY	0	544,352	68,911	613,263	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7,280,670	10,188,050	17,468,720	25 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	0	10,678	2,980	13,658	194.08
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	7,291,348	10,191,030	17,482,378	25 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 8/19/2020 1:53 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	4,338,029				5.00	
7.00	00700	OPERATION OF PLANT	198,880	1,614,728			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	19,539	5,826	45,247		8.00	
9.00	00900	HOUSEKEEPING	70,621	12,511	0	139,491	9.00	
10.00	01000	DIETARY	26,610	20,880	0	1,824	10.00	
11.00	01100	CAFETERIA	22,779	48,653	0	4,251	11.00	
13.00	01300	NURSING ADMINISTRATION	87,632	0	0	0	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	58,040	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	50,623	5,853	0	511	17.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	17,132	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	23,097	3,438	0	300	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	877,950	532,164	20,667	46,502	30.00	
31.00	03100	INTENSIVE CARE UNIT	129,410	161,589	2,649	14,119	31.00	
43.00	04300	NURSERY	21,244	14,537	486	1,270	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	245,357	193,792	0	16,933	50.00	
51.00	05100	RECOVERY ROOM	119,445	45,332	6,820	3,961	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	120,601	69,688	2,327	6,089	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,461	65,328	826	5,708	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	37,884	0	0	0	55.00	
57.00	05700	CT SCAN	49,260	8,023	2,476	701	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,872	8,977	0	784	58.00	
59.00	05900	CARDIAC CATHETERIZATION	109,250	59,117	531	5,166	59.00	
60.00	06000	LABORATORY	188,286	27,442	0	2,398	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	73,977	13,711	0	1,198	65.00	
66.00	06600	PHYSICAL THERAPY	95,738	4,744	0	415	66.00	
67.00	06700	OCCUPATIONAL THERAPY	22,423	1,274	0	111	67.00	
68.00	06800	SPEECH PATHOLOGY	5,171	293	0	26	68.00	
69.00	06900	ELECTROCARDIOLOGY	43,601	33,263	0	2,907	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	28,469	13,337	0	1,165	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	448,386	62,086	0	5,425	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	291,127	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	353,528	33,759	0	2,950	73.00	
74.00	07400	RENAL DIALYSIS	13,661	6,461	0	565	74.00	
76.00	03950	ENDOSCOPY	38,621	0	0	0	76.00	
76.06	03330	IMAGING CENTER	47,096	0	0	0	76.06	
76.97	07697	CARDIAC REHABILITATION	10,613	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	90.00	
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01	
90.02	04951	ANTI-COAGULATION CLINIC	10,267	0	0	0	90.02	
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03	
90.04	04953	SPINE CENTER	7,520	0	0	0	90.04	
91.00	09100	EMERGENCY	242,292	159,521	8,465	13,939	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,308,463	1,611,599	45,247	139,218	147,765	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
191.00	19100	RESEARCH	0	0	0	0	191.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,435	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	LEASED OFFICE SPACE	0	0	0	0	194.06	
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	24,131	3,129	0	273	194.08	
200.00		Cross Foot Adjustments					200.00	
201.00		Negative Cost Centers	0	0	0	0	201.00	
202.00		TOTAL (sum lines 118 through 201)	4,338,029	1,614,728	45,247	139,491	147,765	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 8/19/2020 1:53 pm		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES
		11.00	13.00	16.00	17.00	21.00
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	286,601				11.00
13.00	01300	3,608	91,240			13.00
16.00	01600	1,203	0	59,322		16.00
17.00	01700	6,413	0	0	85,724	17.00
21.00	02100	0	0	0	0	21.00
22.00	02200	0	0	0	0	17,132
22.00	02200	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	112,235	65,005	7,109	73,454	30.00
31.00	03100	12,025	6,965	692	6,311	31.00
43.00	04300	2,405	1,393	240	5,959	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	20,844	0	6,983	0	50.00
51.00	05100	13,228	0	2,358	0	51.00
52.00	05200	12,426	0	1,150	0	52.00
54.00	05400	9,219	0	2,104	0	54.00
55.00	05500	3,608	0	1,286	0	55.00
57.00	05700	4,810	0	3,918	0	57.00
58.00	05800	1,603	0	706	0	58.00
59.00	05900	7,215	0	4,879	0	59.00
60.00	06000	0	0	4,924	0	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	9,620	0	817	0	65.00
66.00	06600	4,409	0	732	0	66.00
67.00	06700	2,806	0	204	0	67.00
68.00	06800	802	0	47	0	68.00
69.00	06900	6,814	0	1,698	0	69.00
70.00	07000	2,405	0	298	0	70.00
71.00	07100	0	0	2,790	0	71.00
72.00	07200	0	0	2,090	0	72.00
73.00	07300	12,827	0	4,102	0	73.00
74.00	07400	0	0	90	0	74.00
76.00	03950	2,806	0	748	0	76.00
76.06	03330	401	0	890	0	76.06
76.97	07697	2,004	0	107	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
90.01	04950	0	0	0	0	90.01
90.02	04951	0	0	67	0	90.02
90.03	04952	0	0	0	0	90.03
90.04	04953	0	0	18	0	90.04
91.00	09100	30,865	17,877	8,275	0	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
118.00		286,601	91,240	59,322	85,724	0
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	0	0	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.06	07956	0	0	0	0	194.06
194.08	07958	0	0	0	0	194.08
200.00						17,132
201.00		0	0	0	0	0
202.00		286,601	91,240	59,322	85,724	17,132

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 8/19/2020 1:53 pm
-------------------------------------	--	-----------------------	---	--

Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM. COSTS				
	22.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	38,568			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	3,896,986	0	3,896,986	30.00
31.00 03100	INTENSIVE CARE UNIT	1,084,360	0	1,084,360	31.00
43.00 04300	NURSERY	106,427	0	106,427	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	2,305,386	0	2,305,386	50.00
51.00 05100	RECOVERY ROOM	376,551	0	376,551	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	494,606	0	494,606	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	664,748	0	664,748	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	299,543	0	299,543	55.00
57.00 05700	CT SCAN	350,926	0	350,926	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	75,576	0	75,576	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,112,294	0	1,112,294	59.00
60.00 06000	LABORATORY	316,774	0	316,774	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	173,266	0	173,266	65.00
66.00 06600	PHYSICAL THERAPY	720,202	0	720,202	66.00
67.00 06700	OCCUPATIONAL THERAPY	58,894	0	58,894	67.00
68.00 06800	SPEECH PATHOLOGY	13,734	0	13,734	68.00
69.00 06900	ELECTROCARDIOLOGY	260,070	0	260,070	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	126,460	0	126,460	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,945,169	0	1,945,169	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	293,217	0	293,217	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	911,553	0	911,553	73.00
74.00 07400	RENAL DIALYSIS	42,927	0	42,927	74.00
76.00 03950	ENDOSCOPY	326,741	0	326,741	76.00
76.06 03330	IMAGING CENTER	222,214	0	222,214	76.06
76.97 07697	CARDIAC REHABILITATION	19,463	0	19,463	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	12,502	0	12,502	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	90.03
90.04 04953	SPINE CENTER	74,966	0	74,966	90.04
91.00 09100	EMERGENCY	1,094,497	0	1,094,497	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	17,380,052	0	17,380,052
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	5,435	0	5,435	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	41,191	0	41,191	194.08
200.00	Cross Foot Adjustments	38,568	55,700	55,700	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	38,568	17,482,378	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	400,832					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		10,322,919				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	25	64,876,327			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,581	3,978,097	4,244,851	-44,365,569	153,995,103	5.00
7.00 00700	OPERATION OF PLANT	75,339	45,978	1,634,842	0	7,060,007	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,093	0	0	0	693,624	8.00
9.00 00900	HOUSEKEEPING	2,347	13,843	1,375,076	0	2,506,952	9.00
10.00 01000	DIETARY	3,917	27,551	362,149	0	944,637	10.00
11.00 01100	CAFETERIA	9,127	45,474	849,009	0	808,631	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	288,151	0	3,110,815	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	80	275,199	0	2,060,331	16.00
17.00 01700	SOCIAL SERVICE	1,098	2,381	1,368,324	0	1,797,039	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	608,162	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	645	0	0	0	819,925	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	99,830	213,313	19,767,504	0	31,166,527	30.00
31.00 03100	INTENSIVE CARE UNIT	30,313	189,170	2,818,231	0	4,593,891	31.00
43.00 04300	NURSERY	2,727	9,407	484,125	0	754,140	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	36,354	1,175,192	3,557,544	0	8,709,853	50.00
51.00 05100	RECOVERY ROOM	8,504	31,112	2,872,967	0	4,240,153	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	13,073	45,096	2,926,186	0	4,281,186	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,255	275,699	1,701,136	0	3,069,264	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	260,088	674,654	0	1,344,825	55.00
57.00 05700	CT SCAN	1,505	257,653	873,840	0	1,748,669	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,684	17,221	339,733	0	563,448	58.00
59.00 05900	CARDIAC CATHETERIZATION	11,090	733,778	1,472,544	0	3,878,225	59.00
60.00 06000	LABORATORY	5,148	80	0	0	6,683,926	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	2,572	27,508	1,821,221	0	2,626,087	65.00
66.00 06600	PHYSICAL THERAPY	890	605,713	2,075,465	0	3,398,565	66.00
67.00 06700	OCCUPATIONAL THERAPY	239	28,087	563,360	0	795,993	67.00
68.00 06800	SPEECH PATHOLOGY	55	6,478	129,929	0	183,579	68.00
69.00 06900	ELECTROCARDIOLOGY	6,240	59,032	867,134	0	1,547,793	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,502	35,729	473,858	0	1,010,629	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,647	1,230,336	0	0	15,917,159	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,334,651	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,333	394,223	2,881,758	0	12,549,802	73.00
74.00 07400	RENAL DIALYSIS	1,212	104	0	0	484,959	74.00
76.00 03950	ENDOSCOPY	0	288,249	642,463	0	1,371,013	76.00
76.06 03330	IMAGING CENTER	0	176,077	863,380	0	1,671,845	76.06
76.97 07697	CARDIAC REHABILITATION	0	6,826	281,800	0	376,744	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	2,196	503,719	0	364,454	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04 04953	SPIRE CENTER	0	68,301	125,168	0	266,968	90.04
91.00 09100	EMERGENCY	29,925	69,803	5,270,852	0	8,601,082	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	400,245	10,319,900	64,386,172	-44,365,569	152,945,553	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	319	0	192,947	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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	587	3,019	489,836	0	856,603	194.08
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)	7,291,348	10,191,030	2,732,750		44,365,569	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.190534	0.987224	0.042122		0.288097	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			25		4,338,029	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1

Date/Time Prepared:
8/19/2020 1:53 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				
205.00	Unit cost multiplier (Wkst. B, Part II)					205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0.000000		0.028170	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (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	302,912				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,093	158,784			8.00
9.00	00900	HOUSEKEEPING	2,347	0	299,472		9.00
10.00	01000	DIETARY	3,917	0	3,917	35,596	10.00
11.00	01100	CAFETERIA	9,127	0	9,127	0	715
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	9
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	3
17.00	01700	SOCIAL SERVICE	1,098	0	1,098	0	16
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	645	0	645	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	99,830	72,527	99,830	32,600	280
31.00	03100	INTENSIVE CARE UNIT	30,313	9,297	30,313	2,996	30
43.00	04300	NURSERY	2,727	1,704	2,727	0	6
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	36,354	0	36,354	0	52
51.00	05100	RECOVERY ROOM	8,504	23,932	8,504	0	33
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,073	8,167	13,073	0	31
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,255	2,899	12,255	0	23
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	9
57.00	05700	CT SCAN	1,505	8,690	1,505	0	12
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,684	0	1,684	0	4
59.00	05900	CARDIAC CATHETERIZATION	11,090	1,862	11,090	0	18
60.00	06000	LABORATORY	5,148	0	5,148	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,572	0	2,572	0	24
66.00	06600	PHYSICAL THERAPY	890	0	890	0	11
67.00	06700	OCCUPATIONAL THERAPY	239	0	239	0	7
68.00	06800	SPEECH PATHOLOGY	55	0	55	0	2
69.00	06900	ELECTROCARDIOLOGY	6,240	0	6,240	0	17
70.00	07000	ELECTROENCEPHALOGRAPHY	2,502	0	2,502	0	6
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,647	0	11,647	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,333	0	6,333	0	32
74.00	07400	RENAL DIALYSIS	1,212	0	1,212	0	0
76.00	03950	ENDOSCOPY	0	0	0	0	7
76.06	03330	IMAGING CENTER	0	0	0	0	1
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	5
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	29,925	29,706	29,925	0	77
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	302,325	158,784	298,885	35,596	715
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	587	0	587	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	9,093,974	926,269	3,299,658	1,377,538	1,416,168
203.00		Unit cost multiplier (Wkst. B, Part I)	30.021835	5.833516	11.018252	38.699236	1,980.654545
204.00		Cost to be allocated (per Wkst. B, Part II)	1,614,728	45,247	139,491	147,765	286,601
205.00		Unit cost multiplier (Wkst. B, Part II)	5.330683	0.284959	0.465790	4.151169	400.840559
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0128			Period: From 01/01/2019 To 12/31/2019		Worksheet B-1 Date/Time Prepared: 8/19/2020 1:53 pm	
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)		
		7.00	8.00	9.00	10.00	11.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00 00500 ADMINISTRATIVE & GENERAL						5.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
13.00 01300 NURSING ADMINISTRATION	393					13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	975,399,358				16.00	
17.00 01700 SOCIAL SERVICE	0	0	40,696			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	77,346		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		77,346	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	280	116,535,240	34,871	60,236	60,236	30.00	
31.00 03100 INTENSIVE CARE UNIT	30	11,342,527	2,996	2,521	2,521	31.00	
43.00 04300 NURSERY	6	3,932,921	2,829	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	114,478,882	0	3,342	3,342	50.00	
51.00 05100 RECOVERY ROOM	0	38,651,555	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	18,854,904	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	34,499,662	0	0	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	21,086,673	0	0	0	55.00	
57.00 05700 CT SCAN	0	64,223,374	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	11,568,422	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	79,979,434	0	0	0	59.00	
60.00 06000 LABORATORY	0	80,717,854	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	13,396,698	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	11,997,527	0	1,247	1,247	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	3,337,172	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	769,399	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	27,828,885	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	4,878,782	0	822	822	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,743,653	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,263,581	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	67,241,793	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	1,472,859	0	0	0	74.00	
76.00 03950 ENDOSCOPY	0	12,263,369	0	0	0	76.00	
76.06 03330 IMAGING CENTER	0	14,593,895	0	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	0	1,747,302	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	1,092,331	0	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	287,410	0	0	0	90.04	
91.00 09100 EMERGENCY	77	138,613,254	0	6,740	6,740	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	393	975,399,358	40,696	74,908	74,908	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	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 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	2,438	2,438	194.08	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	4,024,857	2,659,848	2,391,513	783,372	1,082,614	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10,241.366412	0.002727	58.765309	10.128151	13.997026	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	91,240	59,322	85,724	17,132	38,568	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS		
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	
				13.00	16.00	
205.00 Unit cost multiplier (Wkst. B, Part II)	232.162850	0.000061	2.106448	0.221498	0.498642	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: 15-0128

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

Worksheet C
Part I
Date/Time Prepared:
8/19/2020 1:53 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	51,716,429		51,716,429	0	51,716,429	30.00
31.00	03100 INTENSIVE CARE UNIT	7,905,255		7,905,255	0	7,905,255	31.00
43.00	04300 NURSERY	1,343,566		1,343,566	0	1,343,566	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	13,126,286		13,126,286	0	13,126,286	50.00
51.00	05100 RECOVERY ROOM	6,121,106		6,121,106	0	6,121,106	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,211,559		6,211,559	0	6,211,559	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,613,004		4,613,004	0	4,613,004	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,807,594		1,807,594	0	1,807,594	55.00
57.00	05700 CT SCAN	2,563,818		2,563,818	0	2,563,818	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	834,358		834,358	0	834,358	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,715,282		5,715,282	0	5,715,282	59.00
60.00	06000 LABORATORY	9,040,937		9,040,937	0	9,040,937	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,572,279	0	3,572,279	0	3,572,279	65.00
66.00	06600 PHYSICAL THERAPY	4,468,710	0	4,468,710	0	4,468,710	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,058,089	0	1,058,089	0	1,058,089	67.00
68.00	06800 SPEECH PATHOLOGY	244,784	0	244,784	0	244,784	68.00
69.00	06900 ELECTROCARDIOLOGY	2,359,358		2,359,358	0	2,359,358	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,429,659		1,429,659	0	1,429,659	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,105,582		21,105,582	0	21,105,582	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,405,470		13,405,470	0	13,405,470	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,672,018		16,672,018	0	16,672,018	73.00
74.00	07400 RENAL DIALYSIS	678,430		678,430	0	678,430	74.00
76.00	03950 ENDOSCOPY	1,813,305		1,813,305	0	1,813,305	76.00
76.06	03330 IMAGING CENTER	2,195,278		2,195,278	0	2,195,278	76.06
76.97	07697 CARDIAC REHABILITATION	499,951		499,951	0	499,951	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	472,431		472,431	0	472,431	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	344,665		344,665	0	344,665	90.04
91.00	09100 EMERGENCY	13,799,470		13,799,470	0	13,799,470	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,994,700		6,994,700	0	6,994,700	92.00
200.00	Subtotal (see instructions)	202,113,373	0	202,113,373	0	202,113,373	200.00
201.00	Less Observation Beds	6,994,700		6,994,700	0	6,994,700	201.00
202.00	Total (see instructions)	195,118,673	0	195,118,673	0	195,118,673	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/19/2020 1:53 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	107,791,681		107,791,681		30.00
31.00	03100	INTENSIVE CARE UNIT	11,342,527		11,342,527		31.00
43.00	04300	NURSERY	3,932,921		3,932,921		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	64,529,733	49,949,149	114,478,882	0.114661	50.00
51.00	05100	RECOVERY ROOM	15,031,486	23,620,069	38,651,555	0.158366	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,854,904	0	18,854,904	0.329440	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,098,630	27,401,032	34,499,662	0.133712	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,552,551	14,534,122	21,086,673	0.085722	55.00
57.00	05700	CT SCAN	16,583,761	47,639,613	64,223,374	0.039920	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,244,034	8,324,388	11,568,422	0.072124	58.00
59.00	05900	CARDIAC CATHETERIZATION	33,758,431	46,221,003	79,979,434	0.071459	59.00
60.00	06000	LABORATORY	46,624,519	34,093,335	80,717,854	0.112007	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,510,429	1,886,269	13,396,698	0.266654	65.00
66.00	06600	PHYSICAL THERAPY	3,782,460	8,215,067	11,997,527	0.372469	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,303,730	1,033,442	3,337,172	0.317062	67.00
68.00	06800	SPEECH PATHOLOGY	581,989	187,410	769,399	0.318150	68.00
69.00	06900	ELECTROCARDIOLOGY	8,526,947	19,301,938	27,828,885	0.084781	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	301,424	4,577,358	4,878,782	0.293036	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,301,150	20,442,503	45,743,653	0.461388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,484,702	13,778,879	34,263,581	0.391245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,841,125	24,400,668	67,241,793	0.247941	73.00
74.00	07400	RENAL DIALYSIS	1,472,859	0	1,472,859	0.460621	74.00
76.00	03950	ENDOSCOPY	2,303,523	9,959,846	12,263,369	0.147864	76.00
76.06	03330	IMAGING CENTER	172,342	14,421,553	14,593,895	0.150424	76.06
76.97	07697	CARDIAC REHABILITATION	3,890	1,743,412	1,747,302	0.286127	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	10,655	1,081,676	1,092,331	0.432498	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	287,410	287,410	1.199210	90.04
91.00	09100	EMERGENCY	29,019,808	109,593,446	138,613,254	0.099554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,933,881	5,809,678	8,743,559	0.799983	92.00
200.00		Subtotal (see instructions)	486,896,092	488,503,266	975,399,358		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	486,896,092	488,503,266	975,399,358		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/19/2020 1:53 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.114661		50.00
51.00	05100 RECOVERY ROOM	0.158366		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.329440		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133712		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.085722		55.00
57.00	05700 CT SCAN	0.039920		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.072124		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071459		59.00
60.00	06000 LABORATORY	0.112007		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.266654		65.00
66.00	06600 PHYSICAL THERAPY	0.372469		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.317062		67.00
68.00	06800 SPEECH PATHOLOGY	0.318150		68.00
69.00	06900 ELECTROCARDIOLOGY	0.084781		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.293036		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461388		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.391245		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247941		73.00
74.00	07400 RENAL DIALYSIS	0.460621		74.00
76.00	03950 ENDOSCOPY	0.147864		76.00
76.06	03330 IMAGING CENTER	0.150424		76.06
76.97	07697 CARDIAC REHABILITATION	0.286127		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.432498		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	1.199210		90.04
91.00	09100 EMERGENCY	0.099554		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.799983		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0128

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

Worksheet C
Part I
Date/Time Prepared:
8/19/2020 1:53 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	53,169,633		53,169,633	0	53,169,633	30.00
31.00	03100 INTENSIVE CARE UNIT	7,966,075		7,966,075	0	7,966,075	31.00
43.00	04300 NURSERY	1,343,566		1,343,566	0	1,343,566	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	13,206,912		13,206,912	0	13,206,912	50.00
51.00	05100 RECOVERY ROOM	6,121,106		6,121,106	0	6,121,106	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,211,559		6,211,559	0	6,211,559	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,613,004		4,613,004	0	4,613,004	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,807,594		1,807,594	0	1,807,594	55.00
57.00	05700 CT SCAN	2,563,818		2,563,818	0	2,563,818	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	834,358		834,358	0	834,358	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,715,282		5,715,282	0	5,715,282	59.00
60.00	06000 LABORATORY	9,040,937		9,040,937	0	9,040,937	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,572,279	0	3,572,279	0	3,572,279	65.00
66.00	06600 PHYSICAL THERAPY	4,498,794	0	4,498,794	0	4,498,794	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,058,089	0	1,058,089	0	1,058,089	67.00
68.00	06800 SPEECH PATHOLOGY	244,784	0	244,784	0	244,784	68.00
69.00	06900 ELECTROCARDIOLOGY	2,359,358		2,359,358	0	2,359,358	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,449,490		1,449,490	0	1,449,490	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,105,582		21,105,582	0	21,105,582	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,405,470		13,405,470	0	13,405,470	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,672,018		16,672,018	0	16,672,018	73.00
74.00	07400 RENAL DIALYSIS	678,430		678,430	0	678,430	74.00
76.00	03950 ENDOSCOPY	1,813,305		1,813,305	0	1,813,305	76.00
76.06	03330 IMAGING CENTER	2,195,278		2,195,278	0	2,195,278	76.06
76.97	07697 CARDIAC REHABILITATION	499,951		499,951	0	499,951	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	472,431		472,431	0	472,431	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	344,665		344,665	0	344,665	90.04
91.00	09100 EMERGENCY	13,962,074		13,962,074	0	13,962,074	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,994,700		6,994,700	0	6,994,700	92.00
200.00	Subtotal (see instructions)	203,920,542	0	203,920,542	0	203,920,542	200.00
201.00	Less Observation Beds	6,994,700		6,994,700	0	6,994,700	201.00
202.00	Total (see instructions)	196,925,842	0	196,925,842	0	196,925,842	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/19/2020 1:53 pm
--	--	-----------------------	---	---

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				
Title XIX Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	107,791,681		107,791,681			30.00
31.00	03100	INTENSIVE CARE UNIT	11,342,527		11,342,527			31.00
43.00	04300	NURSERY	3,932,921		3,932,921			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	64,529,733	49,949,149	114,478,882	0.115365	0.000000	50.00
51.00	05100	RECOVERY ROOM	15,031,486	23,620,069	38,651,555	0.158366	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,854,904	0	18,854,904	0.329440	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,098,630	27,401,032	34,499,662	0.133712	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,552,551	14,534,122	21,086,673	0.085722	0.000000	55.00
57.00	05700	CT SCAN	16,583,761	47,639,613	64,223,374	0.039920	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,244,034	8,324,388	11,568,422	0.072124	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	33,758,431	46,221,003	79,979,434	0.071459	0.000000	59.00
60.00	06000	LABORATORY	46,624,519	34,093,335	80,717,854	0.112007	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,510,429	1,886,269	13,396,698	0.266654	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,782,460	8,215,067	11,997,527	0.374977	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,303,730	1,033,442	3,337,172	0.317062	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	581,989	187,410	769,399	0.318150	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,526,947	19,301,938	27,828,885	0.084781	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	301,424	4,577,358	4,878,782	0.297101	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,301,150	20,442,503	45,743,653	0.461388	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,484,702	13,778,879	34,263,581	0.391245	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,841,125	24,400,668	67,241,793	0.247941	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,472,859	0	1,472,859	0.460621	0.000000	74.00
76.00	03950	ENDOSCOPY	2,303,523	9,959,846	12,263,369	0.147864	0.000000	76.00
76.06	03330	IMAGING CENTER	172,342	14,421,553	14,593,895	0.150424	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	3,890	1,743,412	1,747,302	0.286127	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	10,655	1,081,676	1,092,331	0.432498	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.03
90.04	04953	SPINE CENTER	0	287,410	287,410	1.199210	0.000000	90.04
91.00	09100	EMERGENCY	29,019,808	109,593,446	138,613,254	0.100727	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,933,881	5,809,678	8,743,559	0.799983	0.000000	92.00
200.00		Subtotal (see instructions)	486,896,092	488,503,266	975,399,358			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	486,896,092	488,503,266	975,399,358			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/19/2020 1:53 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.115365		50.00
51.00	05100 RECOVERY ROOM	0.158366		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.329440		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133712		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.085722		55.00
57.00	05700 CT SCAN	0.039920		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.072124		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071459		59.00
60.00	06000 LABORATORY	0.112007		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.266654		65.00
66.00	06600 PHYSICAL THERAPY	0.374977		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.317062		67.00
68.00	06800 SPEECH PATHOLOGY	0.318150		68.00
69.00	06900 ELECTROCARDIOLOGY	0.084781		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.297101		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461388		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.391245		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247941		73.00
74.00	07400 RENAL DIALYSIS	0.460621		74.00
76.00	03950 ENDOSCOPY	0.147864		76.00
76.06	03330 IMAGING CENTER	0.150424		76.06
76.97	07697 CARDIAC REHABILITATION	0.286127		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.432498		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	1.199210		90.04
91.00	09100 EMERGENCY	0.100727		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.799983		92.00
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: 15-0128

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

Worksheet C Part II Date/Time Prepared: 8/19/2020 1:53 pm

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	13,206,912	2,305,386	10,901,526	0	0	50.00
51.00	05100	RECOVERY ROOM	6,121,106	376,551	5,744,555	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,211,559	494,606	5,716,953	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,613,004	664,748	3,948,256	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,807,594	299,543	1,508,051	0	0	55.00
57.00	05700	CT SCAN	2,563,818	350,926	2,212,892	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	834,358	75,576	758,782	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,715,282	1,112,294	4,602,988	0	0	59.00
60.00	06000	LABORATORY	9,040,937	316,774	8,724,163	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,572,279	173,266	3,399,013	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,498,794	720,202	3,778,592	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,058,089	58,894	999,195	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	244,784	13,734	231,050	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,359,358	260,070	2,099,288	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,449,490	126,460	1,323,030	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,105,582	1,945,169	19,160,413	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,405,470	293,217	13,112,253	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,672,018	911,553	15,760,465	0	0	73.00
74.00	07400	RENAL DIALYSIS	678,430	42,927	635,503	0	0	74.00
76.00	03950	ENDOSCOPY	1,813,305	326,741	1,486,564	0	0	76.00
76.06	03330	IMAGING CENTER	2,195,278	222,214	1,973,064	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	499,951	19,463	480,488	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	472,431	12,502	459,929	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	344,665	74,966	269,699	0	0	90.04
91.00	09100	EMERGENCY	13,962,074	1,094,497	12,867,577	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,994,700	527,072	6,467,628	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	141,441,268	12,819,351	128,621,917	0	0	200.00
201.00		Less Observation Beds	6,994,700	527,072	6,467,628	0	0	201.00
202.00		Total (line 200 minus line 201)	134,446,568	12,292,279	122,154,289	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part II Date/Time Prepared: 8/19/2020 1:53 pm
---	--	-----------------------	---------------------------------------	---

Cost Center Description		Title XIX			Hospital	PPS
		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)		
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,206,912	114,478,882	0.115365	50.00
51.00	05100	RECOVERY ROOM	6,121,106	38,651,555	0.158366	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,211,559	18,854,904	0.329440	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,613,004	34,499,662	0.133712	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,807,594	21,086,673	0.085722	55.00
57.00	05700	CT SCAN	2,563,818	64,223,374	0.039920	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	834,358	11,568,422	0.072124	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,715,282	79,979,434	0.071459	59.00
60.00	06000	LABORATORY	9,040,937	80,717,854	0.112007	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,572,279	13,396,698	0.266654	65.00
66.00	06600	PHYSICAL THERAPY	4,498,794	11,997,527	0.374977	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,058,089	3,337,172	0.317062	67.00
68.00	06800	SPEECH PATHOLOGY	244,784	769,399	0.318150	68.00
69.00	06900	ELECTROCARDIOLOGY	2,359,358	27,828,885	0.084781	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,449,490	4,878,782	0.297101	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,105,582	45,743,653	0.461388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,405,470	34,263,581	0.391245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,672,018	67,241,793	0.247941	73.00
74.00	07400	RENAL DIALYSIS	678,430	1,472,859	0.460621	74.00
76.00	03950	ENDOSCOPY	1,813,305	12,263,369	0.147864	76.00
76.06	03330	IMAGING CENTER	2,195,278	14,593,895	0.150424	76.06
76.97	07697	CARDIAC REHABILITATION	499,951	1,747,302	0.286127	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	472,431	1,092,331	0.432498	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	344,665	287,410	1.199210	90.04
91.00	09100	EMERGENCY	13,962,074	138,613,254	0.100727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,994,700	8,743,559	0.799983	92.00
200.00		Subtotal (sum of lines 50 thru 199)	141,441,268	852,332,229		200.00
201.00		Less Observation Beds	6,994,700	0		201.00
202.00		Total (line 200 minus line 201)	134,446,568	852,332,229		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part I Date/Time Prepared: 8/19/2020 1:53 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,896,986	0	3,896,986	40,325	96.64	30.00
31.00	INTENSIVE CARE UNIT	1,084,360		1,084,360	2,996	361.94	31.00
43.00	NURSERY	106,427		106,427	2,829	37.62	43.00
200.00	Total (Lines 30 through 199)	5,087,773		5,087,773	46,150		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	11,942	1,154,075				
31.00	INTENSIVE CARE UNIT	1,139	412,250				
43.00	NURSERY	0	0				
200.00	Total (Lines 30 through 199)	13,081	1,566,325				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/19/2020 1:53 pm
--	--	-----------------------	---	--

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,305,386	114,478,882	0.020138	22,935,152	461,868	50.00
51.00	05100	RECOVERY ROOM	376,551	38,651,555	0.009742	4,871,016	47,453	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	494,606	18,854,904	0.026232	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	664,748	34,499,662	0.019268	2,762,968	53,237	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	299,543	21,086,673	0.014205	3,212,198	45,629	55.00
57.00	05700	CT SCAN	350,926	64,223,374	0.005464	6,446,818	35,225	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	75,576	11,568,422	0.006533	1,198,991	7,833	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,112,294	79,979,434	0.013907	11,874,750	165,142	59.00
60.00	06000	LABORATORY	316,774	80,717,854	0.003924	17,094,129	67,077	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	173,266	13,396,698	0.012933	3,939,792	50,953	65.00
66.00	06600	PHYSICAL THERAPY	720,202	11,997,527	0.060029	1,686,774	101,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,894	3,337,172	0.017648	1,096,961	19,359	67.00
68.00	06800	SPEECH PATHOLOGY	13,734	769,399	0.017850	272,429	4,863	68.00
69.00	06900	ELECTROCARDIOLOGY	260,070	27,828,885	0.009345	3,601,082	33,652	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	126,460	4,878,782	0.025920	112,740	2,922	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,945,169	45,743,653	0.042523	8,200,719	348,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	293,217	34,263,581	0.008558	8,132,140	69,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	911,553	67,241,793	0.013556	14,208,684	192,613	73.00
74.00	07400	RENAL DIALYSIS	42,927	1,472,859	0.029145	822,006	23,957	74.00
76.00	03950	ENDOSCOPY	326,741	12,263,369	0.026644	25,216	672	76.00
76.06	03330	IMAGING CENTER	222,214	14,593,895	0.015227	50,448	768	76.06
76.97	07697	CARDIAC REHABILITATION	19,463	1,747,302	0.011139	586	7	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	12,502	1,092,331	0.011445	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	74,966	287,410	0.260833	0	0	90.04
91.00	09100	EMERGENCY	1,094,497	138,613,254	0.007896	11,530,431	91,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	527,072	8,743,559	0.060281	1,408,903	84,930	92.00
200.00		Total (lines 50 through 199)	12,819,351	852,332,229		125,484,933	1,908,773	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Prepared: 8/19/2020 1:53 pm
---	-----------------------	---	---

Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	40,325	0.00	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,996	0.00	31.00	
43.00	04300	NURSERY	0	0	2,829	0.00	43.00	
200.00		Total (lines 30 through 199)	0	0	46,150	0.00	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
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: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---	--

Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
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	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---	--

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	114,478,882	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	38,651,555	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	18,854,904	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	34,499,662	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	21,086,673	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	64,223,374	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,568,422	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	79,979,434	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	80,717,854	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	13,396,698	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	11,997,527	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	3,337,172	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	769,399	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	27,828,885	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	4,878,782	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	45,743,653	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	34,263,581	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	67,241,793	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	1,472,859	0.000000	74.00
76.00 03950 ENDOSCOPY	0	0	0	12,263,369	0.000000	76.00
76.06 03330 IMAGING CENTER	0	0	0	14,593,895	0.000000	76.06
76.97 07697 CARDIAC REHABILITATION	0	0	0	1,747,302	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02 04951 ANTI-COAGULATION CLINIC	0	0	0	1,092,331	0.000000	90.02
90.03 04952 PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04 04953 SPINE CENTER	0	0	0	287,410	0.000000	90.04
91.00 09100 EMERGENCY	0	0	0	138,613,254	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,743,559	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	852,332,229		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---------------------------------------	---

Cost Center Description	Title XVIII					Hospital	
	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 before Recl assi fi cation	Outpatient Program Charges on/after Geo Recl assi fi cation	PPS	
						9.00	10.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.000000	22,935,152	0	9,789,446	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	4,871,016	0	5,331,922	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,762,968	0	6,337,169	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	3,212,198	0	7,154,105	0	0	55.00
57.00 05700 CT SCAN	0.000000	6,446,818	0	10,203,190	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,198,991	0	1,960,927	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	11,874,750	0	16,368,900	0	0	59.00
60.00 06000 LABORATORY	0.000000	17,094,129	0	6,295,928	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.000000	3,939,792	0	303,606	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	1,686,774	0	89,255	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	1,096,961	0	23,232	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	272,429	0	3,341	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	3,601,082	0	5,686,095	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	112,740	0	926,441	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	8,200,719	0	5,447,105	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	8,132,140	0	5,128,890	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	14,208,684	0	6,799,944	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	822,006	0	0	0	0	74.00
76.00 03950 ENDOSCOPY	0.000000	25,216	0	2,925,798	0	0	76.00
76.06 03330 IMAGING CENTER	0.000000	50,448	0	3,127,076	0	0	76.06
76.97 07697 CARDIAC REHABILITATION	0.000000	586	0	703,670	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.000000	0	0	0	0	0	90.00
90.01 04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	0	90.01
90.02 04951 ANTI-COAGULATION CLINIC	0.000000	0	0	642,806	0	0	90.02
90.03 04952 PALLIATIVE CARE	0.000000	0	0	0	0	0	90.03
90.04 04953 SPINE CENTER	0.000000	0	0	389	0	0	90.04
91.00 09100 EMERGENCY	0.000000	11,530,431	0	14,497,695	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,408,903	0	3,466,665	0	0	92.00
200.00 Total (lines 50 through 199)		125,484,933	0	113,213,595	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/19/2020 1:53 pm
	Title XVIII	Hospital	PPS

Cost Center Description		Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geographical Reclassification 13.00	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geographical Reclassification 13.01	
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 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
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 PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ENDOSCOPY	0	0	76.00
76.06	03330 IMAGING CENTER	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	90.03
90.04	04953 SPINE CENTER	0	0	90.04
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/19/2020 1:53 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	0.114661	9,789,446	0	0	1,122,468	50.00
51.00	05100	RECOVERY ROOM	0.158366	5,331,922	0	0	844,395	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.329440	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133712	6,337,169	0	0	847,356	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.085722	7,154,105	0	0	613,264	55.00
57.00	05700	CT SCAN	0.039920	10,203,190	0	0	407,311	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072124	1,960,927	0	0	141,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.071459	16,368,900	0	0	1,169,705	59.00
60.00	06000	LABORATORY	0.112007	6,295,928	0	0	705,188	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.266654	303,606	0	0	80,958	65.00
66.00	06600	PHYSICAL THERAPY	0.372469	89,255	0	0	33,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.317062	23,232	0	0	7,366	67.00
68.00	06800	SPEECH PATHOLOGY	0.318150	3,341	0	0	1,063	68.00
69.00	06900	ELECTROCARDIOLOGY	0.084781	5,686,095	0	0	482,073	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.293036	926,441	0	0	271,481	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461388	5,447,105	0	0	2,513,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391245	5,128,890	0	0	2,006,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247941	6,799,944	0	101,815	1,685,985	73.00
74.00	07400	RENAL DIALYSIS	0.460621	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.147864	2,925,798	0	0	432,620	76.00
76.06	03330	IMAGING CENTER	0.150424	3,127,076	0	0	470,387	76.06
76.97	07697	CARDIAC REHABILITATION	0.286127	703,670	0	0	201,339	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.432498	642,806	0	0	278,012	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPIRE CENTER	1.199210	389	0	0	466	90.04
91.00	09100	EMERGENCY	0.099554	14,497,695	0	89	1,443,304	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.799983	3,466,665	0	25	2,773,273	92.00
200.00		Subtotal (see instructions)		113,213,595	0	101,929	18,532,571	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		113,213,595	0	101,929	18,532,571	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/19/2020 1:53 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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
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 PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,244	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	0	90.04
91.00	09100	EMERGENCY	0	9	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	20	92.00
200.00		Subtotal (see instructions)	0	25,273	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	25,273	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part I Date/Time Prepared: 8/19/2020 1:53 pm	
Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,896,986	0	3,896,986	40,325	96.64	30.00
31.00	INTENSIVE CARE UNIT	1,084,360		1,084,360	2,996	361.94	31.00
43.00	NURSERY	106,427		106,427	2,829	37.62	43.00
200.00	Total (Lines 30 through 199)	5,087,773		5,087,773	46,150		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	1,554	150,179				
31.00	INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	1,718	64,631				
200.00	Total (Lines 30 through 199)	3,272	214,810				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/19/2020 1:53 pm
--	--	-----------------------	---	--

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	2,305,386	114,478,882	0.020138	1,117,535	22,505	50.00
51.00	05100	RECOVERY ROOM	376,551	38,651,555	0.009742	384,023	3,741	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	494,606	18,854,904	0.026232	219,802	5,766	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	664,748	34,499,662	0.019268	304,100	5,859	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	299,543	21,086,673	0.014205	164,499	2,337	55.00
57.00	05700	CT SCAN	350,926	64,223,374	0.005464	666,590	3,642	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	75,576	11,568,422	0.006533	158,319	1,034	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,112,294	79,979,434	0.013907	1,269,439	17,654	59.00
60.00	06000	LABORATORY	316,774	80,717,854	0.003924	2,145,335	8,418	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	173,266	13,396,698	0.012933	397,917	5,146	65.00
66.00	06600	PHYSICAL THERAPY	720,202	11,997,527	0.060029	106,060	6,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,894	3,337,172	0.017648	50,948	899	67.00
68.00	06800	SPEECH PATHOLOGY	13,734	769,399	0.017850	22,478	401	68.00
69.00	06900	ELECTROCARDIOLOGY	260,070	27,828,885	0.009345	304,440	2,845	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	126,460	4,878,782	0.025920	21,378	554	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,945,169	45,743,653	0.042523	1,095,357	46,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	293,217	34,263,581	0.008558	252,225	2,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	911,553	67,241,793	0.013556	1,856,934	25,173	73.00
74.00	07400	RENAL DIALYSIS	42,927	1,472,859	0.029145	51,837	1,511	74.00
76.00	03950	ENDOSCOPY	326,741	12,263,369	0.026644	68,220	1,818	76.00
76.06	03330	IMAGING CENTER	222,214	14,593,895	0.015227	9,443	144	76.06
76.97	07697	CARDIAC REHABILITATION	19,463	1,747,302	0.011139	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	12,502	1,092,331	0.011445	242	3	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	74,966	287,410	0.260833	0	0	90.04
91.00	09100	EMERGENCY	1,094,497	138,613,254	0.007896	1,161,846	9,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	527,069	8,743,559	0.060281	22,273	1,343	92.00
200.00		Total (lines 50 through 199)	12,819,348	852,332,229		11,851,240	175,071	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Prepared: 8/19/2020 1:53 pm
---	-----------------------	---	---

Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	40,325	0.00	1,554	30.00
31.00	03100	INTENSIVE CARE UNIT		2,996	0.00	0	31.00
43.00	04300	NURSERY		2,829	0.00	1,718	43.00
200.00		Total (lines 30 through 199)		46,150		3,272	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
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: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---	--

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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
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	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---	--

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Title XIX		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
				Hospital	PPS	
	4.00	5.00	6.00	Total Charges (from Wkst. C, Part I, col. 8)	7.00	8.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	114,478,882	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	38,651,555	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	18,854,904	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	34,499,662	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	21,086,673	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	64,223,374	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,568,422	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	79,979,434	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	80,717,854	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	13,396,698	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	11,997,527	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	3,337,172	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	769,399	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	27,828,885	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	4,878,782	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	45,743,653	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	34,263,581	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	67,241,793	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	1,472,859	0.000000	74.00
76.00 03950 ENDOSCOPY	0	0	0	12,263,369	0.000000	76.00
76.06 03330 IMAGING CENTER	0	0	0	14,593,895	0.000000	76.06
76.97 07697 CARDIAC REHABILITATION	0	0	0	1,747,302	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02 04951 ANTI-COAGULATION CLINIC	0	0	0	1,092,331	0.000000	90.02
90.03 04952 PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04 04953 SPINE CENTER	0	0	0	287,410	0.000000	90.04
91.00 09100 EMERGENCY	0	0	0	138,613,254	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,743,559	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	852,332,229		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---------------------------------------	---

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 before Geo Recl assi fi cation	Outpatient Program Charges on/after Geo Recl assi fi cation	
	9.00	10.00	11.00	12.00	12.01	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	1,117,535	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	384,023	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	219,802	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	304,100	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	164,499	0	0	0	55.00
57.00 05700 CT SCAN	0.000000	666,590	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	158,319	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	1,269,439	0	0	0	59.00
60.00 06000 LABORATORY	0.000000	2,145,335	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.000000	397,917	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	106,060	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	50,948	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	22,478	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	304,440	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	21,378	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,095,357	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	252,225	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	1,856,934	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	51,837	0	0	0	74.00
76.00 03950 ENDOSCOPY	0.000000	68,220	0	0	0	76.00
76.06 03330 IMAGING CENTER	0.000000	9,443	0	0	0	76.06
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02 04951 ANTI-COAGULATION CLINIC	0.000000	242	0	0	0	90.02
90.03 04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04 04953 SPINE CENTER	0.000000	0	0	0	0	90.04
91.00 09100 EMERGENCY	0.000000	1,161,846	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	22,273	0	0	0	92.00
200.00 Total (lines 50 through 199)		11,851,240	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---	--

Cost Center Description		Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geographical Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geographical Reclassification	Title XIX	Hospital	PPS
		13.00	13.01			
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 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
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 PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
76.00	03950 ENDOSCOPY	0	0			76.00
76.06	03330 IMAGING CENTER	0	0			76.06
76.97	07697 CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0			90.00
90.01	04950 DIABETIC CARE CENTER	0	0			90.01
90.02	04951 ANTI-COAGULATION CLINIC	0	0			90.02
90.03	04952 PALLIATIVE CARE	0	0			90.03
90.04	04953 SPINE CENTER	0	0			90.04
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50 through 199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/19/2020 1:53 pm
		Title XIX	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	0.115365	0	873,684	0	0	50.00
51.00	05100 RECOVERY ROOM	0.158366	0	479,210	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.329440	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133712	0	1,071,742	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.085722	0	455,589	0	0	55.00
57.00	05700 CT SCAN	0.039920	0	2,431,130	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.072124	0	222,734	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071459	0	390,108	0	0	59.00
60.00	06000 LABORATORY	0.112007	0	2,002,568	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.266654	0	65,971	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.374977	0	95,021	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.317062	0	13,599	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.318150	0	7,295	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.084781	0	232,773	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.297101	0	29,719	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461388	0	661,543	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.391245	0	195,060	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247941	0	371,233	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.460621	0	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.147864	0	122,486	0	0	76.00
76.06	03330 IMAGING CENTER	0.150424	0	166,725	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.286127	0	605	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.432498	0	14,370	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	1.199210	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.100727	0	8,634,172	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.799983	0	5,263	0	0	92.00
200.00	Subtotal (see instructions)		0	18,542,600	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	18,542,600	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/19/2020 1:53 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	100,793	0		50.00
51.00 05100 RECOVERY ROOM	75,891	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	143,305	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	39,054	0		55.00
57.00 05700 CT SCAN	97,051	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	16,064	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	27,877	0		59.00
60.00 06000 LABORATORY	224,302	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	17,591	0		65.00
66.00 06600 PHYSICAL THERAPY	35,631	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	4,312	0		67.00
68.00 06800 SPEECH PATHOLOGY	2,321	0		68.00
69.00 06900 ELECTROCARDIOLOGY	19,735	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	8,830	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	305,228	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	76,316	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	92,044	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 ENDOSCOPY	18,111	0		76.00
76.06 03330 IMAGING CENTER	25,079	0		76.06
76.97 07697 CARDIAC REHABILITATION	173	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 DIABETIC CARE CENTER	0	0		90.01
90.02 04951 ANTI-COAGULATION CLINIC	6,215	0		90.02
90.03 04952 PALLIATIVE CARE	0	0		90.03
90.04 04953 SPINE CENTER	0	0		90.04
91.00 09100 EMERGENCY	869,694	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,210	0		92.00
200.00 Subtotal (see instructions)	2,209,827	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	2,209,827	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 8/19/2020 1:53 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,325	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,325	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)		34,871	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)		11,942	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)		51,716,429	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		51,716,429	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		51,716,429	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)		1,282.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,315,496	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		15,315,496	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/19/2020 1:53 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	7,905,255	2,996	2,638.60	1,139	3,005,365	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					22,758,076	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					41,078,937	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,566,325	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,908,773	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,475,098	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					37,603,839	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					5,454	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,282.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,994,700	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/19/2020 1:53 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	3,896,986	51,716,429	0.075353	6,994,700	527,072	90.00
91.00	Nursing School cost	0	51,716,429	0.000000	6,994,700	0	91.00
92.00	Allied health cost	0	51,716,429	0.000000	6,994,700	0	92.00
93.00	All other Medical Education	0	51,716,429	0.000000	6,994,700	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 8/19/2020 1:53 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,325	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,325	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)		34,871	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,554	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		2,829	15.00
16.00	Nursery days (title V or XIX only)		1,718	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)		53,169,633	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)		53,169,633	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)		53,169,633	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)		1,318.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,048,996	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)		2,048,996	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1		
		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)	1,343,566	2,829	474.93	1,718	815,930	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	7,966,075	2,996	2,658.90	0	0	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
		1.00						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						2,122,106	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						4,987,032	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)						214,810	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						175,071	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						389,881	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						4,597,151	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						5,454	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,318.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						7,191,263	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/19/2020 1:53 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	3,896,986	53,169,633	0.073293	7,191,263	527,069	90.00
91.00	Nursing School cost	0	53,169,633	0.000000	7,191,263	0	91.00
92.00	Allied health cost	0	53,169,633	0.000000	7,191,263	0	92.00
93.00	All other Medical Education	0	53,169,633	0.000000	7,191,263	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/19/2020 1:53 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		25,852,546		30.00
31.00	03100 INTENSIVE CARE UNIT		4,032,163		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.114661	22,935,152	2,629,767	50.00
51.00	05100 RECOVERY ROOM	0.158366	4,871,016	771,403	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.329440	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133712	2,762,968	369,442	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.085722	3,212,198	275,356	55.00
57.00	05700 CT SCAN	0.039920	6,446,818	257,357	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.072124	1,198,991	86,476	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071459	11,874,750	848,558	59.00
60.00	06000 LABORATORY	0.112007	17,094,129	1,914,662	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.266654	3,939,792	1,050,561	65.00
66.00	06600 PHYSICAL THERAPY	0.372469	1,686,774	628,271	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.317062	1,096,961	347,805	67.00
68.00	06800 SPEECH PATHOLOGY	0.318150	272,429	86,673	68.00
69.00	06900 ELECTROCARDIOLOGY	0.084781	3,601,082	305,303	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.293036	112,740	33,037	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461388	8,200,719	3,783,713	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.391245	8,132,140	3,181,659	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247941	14,208,684	3,522,915	73.00
74.00	07400 RENAL DIALYSIS	0.460621	822,006	378,633	74.00
76.00	03950 ENDOSCOPY	0.147864	25,216	3,729	76.00
76.06	03330 IMAGING CENTER	0.150424	50,448	7,589	76.06
76.97	07697 CARDIAC REHABILITATION	0.286127	586	168	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.432498	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953 SPINE CENTER	1.199210	0	0	90.04
91.00	09100 EMERGENCY	0.099554	11,530,431	1,147,901	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.799983	1,408,903	1,127,098	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		125,484,933	22,758,076	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)		125,484,933		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/19/2020 1:53 pm
--	--	-----------------------	---	---

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		5,394,764	30.00
31.00	03100	INTENSIVE CARE UNIT		517,528	31.00
43.00	04300	NURSERY		256,603	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.115365	1,117,535	128,924 50.00
51.00	05100	RECOVERY ROOM	0.158366	384,023	60,816 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.329440	219,802	72,412 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133712	304,100	40,662 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.085722	164,499	14,101 55.00
57.00	05700	CT SCAN	0.039920	666,590	26,610 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072124	158,319	11,419 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.071459	1,269,439	90,713 59.00
60.00	06000	LABORATORY	0.112007	2,145,335	240,293 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.266654	397,917	106,106 65.00
66.00	06600	PHYSICAL THERAPY	0.374977	106,060	39,770 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.317062	50,948	16,154 67.00
68.00	06800	SPEECH PATHOLOGY	0.318150	22,478	7,151 68.00
69.00	06900	ELECTROCARDIOLOGY	0.084781	304,440	25,811 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.297101	21,378	6,351 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461388	1,095,357	505,385 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391245	252,225	98,682 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247941	1,856,934	460,410 73.00
74.00	07400	RENAL DIALYSIS	0.460621	51,837	23,877 74.00
76.00	03950	ENDOSCOPY	0.147864	68,220	10,087 76.00
76.06	03330	IMAGING CENTER	0.150424	9,443	1,420 76.06
76.97	07697	CARDIAC REHABILITATION	0.286127	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0 90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.432498	242	105 90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0 90.03
90.04	04953	SPINE CENTER	1.199210	0	0 90.04
91.00	09100	EMERGENCY	0.100727	1,161,846	117,029 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.799983	22,273	17,818 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,851,240	2,122,106 200.00
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)		11,851,240	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/19/2020 1:53 pm
		Title XVIII	Hospital	PPS
		Before GEO Recl ass	On/After GEO Recl ass	
		1.00	1.01	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	21,779,931	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	6,974,605	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	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	0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount	0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	562,143	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	99,435	2.04
3.00	Managed Care Simulated Payments	9,288,571	3,506,011	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	153.04		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).	6.21		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)	6.21		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	6.38		10.00
11.00	FTE count for residents in dental and podiatric programs.	1.36		11.00
12.00	Current year allowable FTE (see instructions)	7.57		12.00
13.00	Total allowable FTE count for the prior year.	7.54		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.	6.88		14.00
15.00	Sum of lines 12 through 14 divided by 3.	7.33		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	7.33		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.047896		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.048601		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.047896		21.00
22.00	IME payment adjustment (see instructions)	562,423	180,105	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	239,859	90,536	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)	0.17		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	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	562,423	180,105	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	239,859	90,536	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.64		30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.71		31.00
32.00	Sum of lines 30 and 31	25.35		32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.13	10.13	33.00
34.00	Disproportionate share adjustment (see instructions)	551,577	176,632	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/19/2020 1:53 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)	0.000193416	0.000168507	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,600,102	1,407,133	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,196,788	353,705	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,550,493		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
		Before GEO Recl ass	On/After GEO Recl ass	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	24,652,862	7,784,482	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0	0	48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		32,767,739	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,529,697	50.00
51.00	Exception on 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).		200,153	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		36,425	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)		35,534,014	59.00
60.00	Primary payer payments		7,193	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,526,821	61.00
62.00	Deductibles billed to program beneficiaries		3,103,696	62.00
63.00	Coinurance billed to program beneficiaries		49,104	63.00
64.00	Allowable bad debts (see instructions)		263,811	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		171,477	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		42,587	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		32,545,498	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)		-84,614	70.93
70.94	HRR adjustment amount (see instructions)		-203,467	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/19/2020 1:53 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	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)		82,369	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		32,175,048	71.00
71.01	Sequestration adjustment (see instructions)		643,501	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		30,951,540	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		580,007	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		716,516	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	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	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: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/19/2020 1:53 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		25,273	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,532,571	2.00
3.00	OPPS payments		16,215,806	3.00
4.00	Outlier payment (see instructions)		56,306	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)		25,273	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		101,929	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)		101,929	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)		101,929	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		76,656	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)		25,273	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)		16,272,112	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,826,739	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)		13,470,646	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		90,374	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)		13,561,020	30.00
31.00	Primary payer payments		13,074	31.00
32.00	Subtotal (line 30 minus line 31)		13,547,946	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)		484,425	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		314,876	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		308,265	36.00
37.00	Subtotal (see instructions)		13,862,822	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-51	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		40,425	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		13,862,873	40.00
40.01	Sequestration adjustment (see instructions)		277,257	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		13,420,696	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		164,920	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0128

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

Worksheet E-1
Part I
Date/Time Prepared:
8/19/2020 1:53 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		30,951,540		13,420,696	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)		30,951,540		13,420,696	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		580,007		164,920	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		31,531,547		13,585,616	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: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/19/2020 1:53 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 8/19/2020 1:53 pm
--	-----------------------	---	---

Title XVIII		Hospital	PPS
			1.00

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			6.21	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)			6.21	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6.38	6.00
7.00	Enter the lesser of line 5 or line 6			6.21	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.	5.71	0.67	6.38	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.	5.56	0.65	6.21	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.36		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	5.56	2.01		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.45	0.64		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.01	0.74		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.34	1.13		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	5.34	1.13		17.00
18.00	Per resident amount	91,900.40	91,900.40		18.00
19.00	Approved amount for resident costs	490,748	103,847	594,595	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)				0.17	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)				594,595	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)	13,081	6,162		26.00
27.00	Total Inpatient Days (see instructions)	38,500	38,500		27.00
28.00	Ratio of inpatient days to total inpatient days	0.339766	0.160052		28.00
29.00	Program direct GME amount	202,023	95,166	297,189	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		6,662	6,662	30.00
31.00	Net Program direct GME amount			290,527	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 8/19/2020 1:53 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,472,859	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)		41,078,937	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)		7,193	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		41,071,744	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		18,557,844	42.00
43.00	Primary payer payments (see instructions)		13,074	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		18,544,770	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		59,616,514	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.688932	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.311068	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		290,527	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		200,153	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		90,374	50.00

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

Provider CCN: 15-0128

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

Worksheet G

Date/Time Prepared:
8/19/2020 1:53 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,849	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	183,566,569	0	0	0	4.00
5.00	Other receivable	-144,164,341	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	529,743	0	0	0	6.00
7.00	Inventory	3,673,051	0	0	0	7.00
8.00	Prepaid expenses	130,000	0	0	0	8.00
9.00	Other current assets	49,666	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)	43,790,537	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,254,312	0	0	0	12.00
13.00	Land improvements	2,722,362	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	183,134,843	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,737,035	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	82,420,201	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	59,805	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	-136,432,656	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	115,657	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	135,011,559	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	426,604,547	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	426,604,547	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	605,406,643	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	972,604	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	1,491,595	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,464,199	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	753,787	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	753,787	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,217,986	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	602,188,657	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)	602,188,657	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	605,406,643	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0128

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

Worksheet G-1

Date/Time Prepared:
8/19/2020 1:53 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		538,142,909		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		64,045,748			2.00
3.00	Total (sum of line 1 and line 2)		602,188,657		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)		602,188,657		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)		602,188,657		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: 15-0128

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/19/2020 1:53 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	115,664,651		115,664,651	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	115,664,651		115,664,651	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	11,290,640		11,290,640	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,290,640		11,290,640	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	126,955,291		126,955,291	17.00
18.00	Ancillary services	345,102,969	517,515,936	862,618,905	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	OTHER (SPECIFY)	0	75,636	75,636	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	472,058,260	517,591,572	989,649,832	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		234,002,345		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)		234,002,345		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0128

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

Worksheet G-3

Date/Time Prepared:
8/19/2020 1:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	989,649,832	1.00
2.00	Less contractual allowances and discounts on patients' accounts	695,230,056	2.00
3.00	Net patient revenues (line 1 minus line 2)	294,419,776	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	234,002,345	4.00
5.00	Net income from service to patients (line 3 minus line 4)	60,417,431	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	166,726	6.00
7.00	Income from investments	829,321	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	11,797	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,357,812	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	797,642	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	508,519	24.00
25.00	Total other income (sum of lines 6-24)	3,671,817	25.00
26.00	Total (line 5 plus line 25)	64,089,248	26.00
27.00	TAXES	43,500	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	43,500	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	64,045,748	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/19/2020 1:53 pm	
		Title XVIII	Hospital	PPS	
			Urban	Rural	
			1.00	1.01	
PART I - FULLY PROSPECTIVE METHOD					
CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier		1,772,087	555,331	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	0	1.01
2.00	Capital DRG outlier payments		63,682		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)		107.10		3.00
4.00	Number of interns & residents (see instructions)		7.33		4.00
5.00	Indirect medical education percentage (see instructions)		1.95		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)		45,385		6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.64		7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.71		8.00
9.00	Sum of lines 7 and 8		25.35		9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.26		10.00
11.00	Disproportionate share adjustment (see instructions)		93,212		11.00
12.00	Total prospective capital payments (see instructions)		2,529,697		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