

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: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/25/2020 8:03 am
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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: 6/25/2020 Time: 8:03 am

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 METHODIST HOSPITALS, INC (15-0002) 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) MATTHEW DOYLE
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,006,597	-215,772	0	-1,156,846	1.00
2.00 Subprovider - IPF	0	4,010	0		0	2.00
3.00 Subprovider - IRF	0	28,927	2		55,210	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00 Total	0	1,039,534	-215,771	0	-1,101,636	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: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/25/2020 8:03 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 600 GRANT STREET			PO Box:							1.00
2.00	City: GARY			State: IN		Zip Code: 46402		County: LAKE			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		METHODIST HOSPITALS, INC	150002	23844	1	01/01/1966	N	P	0	3.00
4.00	Subprovider - IPF		GERIATRIC PSYCH	15S002	23844	4	01/01/2012	N	P	0	4.00
5.00	Subprovider - IRF		REHABILITATION	15T002	23844	5	01/01/1984	N	P	0	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		METHODIST HOME CARE SERVICES	157536	23844		02/12/2002	N	P	0	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019		20.00	
21.00	Type of Control (see instructions)						2			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		N	22.03	
23.00	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.										
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			3,148	6,113	556	728	14,468	0	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002			Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/25/2020 8:03 am		
		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.	139	301	0	0	569		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.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	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	N		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 Criteria on Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			Y	N			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)				23.00	2		60.01	

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
					1.00		
62.00	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
63.00	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.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/25/2020 8:03 am	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00	
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N	111.00	
						1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				N	112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N	116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y	117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				1	118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	1,143,153		0	995,200	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/25/2020 8:03 am	
		1.00	2.00				
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)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:		Zip Code:		142.00	
143.00	City:	State:				143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/25/2020 8:03 am
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 6/25/2020 8:03 am	
		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)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	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	03/27/2019	Y	03/27/2019		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: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/25/2020 8:03 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				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.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM	43.00

		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.	DIRECTOR	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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
6/25/2020 8:03 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
	Line Number				Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	375	136,875	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)		375	136,875	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	27	9,855	0.00	0	8.00
8.01 NEONATAL ICU	31.01	36	13,140	0.00	0	8.01
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)		438	159,870	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00 SUBPROVIDER - IRF	41.00	39	14,235		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		491			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
6/25/2020 8:03 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	22,149	2,762	64,992			1.00
2.00 HMO and other (see instructions)	16,082	21,809				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	870				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)	22,149	2,762	64,992			7.00
8.00 INTENSIVE CARE UNIT	4,320	0	7,574			8.00
8.01 NEONATAL ICU	0	0	2,213			8.01
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		381	2,632			13.00
14.00 Total (see instructions)	26,469	3,143	77,411	0.00	1,989.56	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,363	0	3,016	0.00	14.85	16.00
17.00 SUBPROVIDER - IRF	4,740	139	7,786	0.00	37.05	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	6,763	4,182	21,756	0.00	26.69	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			304			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	2,068.15	27.00
28.00 Observation Bed Days		6,279	19,770			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	61	70			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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
6/25/2020 8:03 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	4,441	450	12,796	1.00
2.00 HMO and other (see instructions)				2,082	419		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					57		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
8.01 NEONATAL ICU							8.01
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	4,441	450		12,796	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	64	0		240	16.00
17.00 SUBPROVIDER - IRF	0.00	0	269	10		461	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	0.00						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: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
6/25/2020 8:03 am

	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	149,182,530	-288,714	148,893,816	4,301,742.00	34.61
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthesiologist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		3,232,882	0	3,232,882	26,349.00	122.69
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)		222,850	0	222,850	6,240.00	35.71
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)		28,451,475	434,924	28,886,399	574,431.00	50.29
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		7,130,660	0	7,130,660	119,879.00	59.48
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		725,651	0	725,651	5,183.00	140.01
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		0	0	0	0.00	0.00
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)		34,151,150	0	34,151,150		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,950,880	0	5,950,880		
20.00	Non-physician anesthesiologist Part A		0	0	0		
21.00	Non-physician anesthesiologist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		433,803	0	433,803		
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)		0	0	0		
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: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
6/25/2020 8:03 am

	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	1,683,288	-55,100	1,628,188	3,704.00	439.58	26.00
27.00	Administrative & General	21,085,016	-701,322	20,383,694	645,281.00	31.59	27.00
28.00	Administrative & General under contract (see inst.)	1,726,611	0	1,726,611	8,992.00	192.02	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	3,830,966	-9,268	3,821,698	153,661.00	24.87	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	4,488,456	-27,123	4,461,333	285,589.00	15.62	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	3,342,731	-1,291,672	2,051,059	102,628.00	19.99	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	255,262	1,287,486	1,542,748	76,983.00	20.04	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	3,220,339	2,088	3,222,427	65,855.00	48.93	38.00
39.00	Central Services and Supply	619,842	0	619,842	33,147.00	18.70	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	1,970,757	-3,882	1,966,875	82,469.00	23.85	41.00
42.00	Social Service	0	407,414	407,414	13,752.00	29.63	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part III
Date/Time Prepared:
6/25/2020 8:03 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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)	147,453,409	-288,714	147,164,695	4,278,145.00	34.40	1.00
2.00	Excluded area salaries (see instructions)	28,451,475	434,924	28,886,399	574,431.00	50.29	2.00
3.00	Subtotal salaries (line 1 minus line 2)	119,001,934	-723,638	118,278,296	3,703,714.00	31.94	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,856,311	0	7,856,311	125,062.00	62.82	4.00
5.00	Subtotal wage-related costs (see inst.)	34,151,150	0	34,151,150	0.00	28.87	5.00
6.00	Total (sum of lines 3 thru 5)	161,009,395	-723,638	160,285,757	3,828,776.00	41.86	6.00
7.00	Total overhead cost (see instructions)	42,223,268	-391,379	41,831,889	1,472,061.00	28.42	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 6/25/2020 8:03 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,101,207	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	5,084,027	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	16,784,840	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	3,049,460	9.00
10.00	Dental, Hearing and Vision Plan	887,881	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	442,170	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)	288,714	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,290,285	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	10,233,004	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	90,806	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	283,439	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	40,535,833	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: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part V Date/Time Prepared: 6/25/2020 8:03 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	7,130,660	40,535,833	1.00
2.00	Hospital	7,130,660	40,535,833	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0002 Component CCN: 15-7536	Period: From 01/01/2019 To 12/31/2019	Worksheet S-4 Date/Time Prepared: 6/25/2020 8:03 am
			Home Health Agency I	PPS

		1.00					
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	286.00	0.00	0.00	0.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			7.38	0.00	7.38	5.00
6.00	Direct Nursing Service			11.11	0.00	11.11	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.51	0.00	4.51	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.21	0.00	1.21	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.35	0.00	0.35	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.04	0.00	0.04	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			2.14	0.00	2.14	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			23844			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (col s. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	3,090	413	86	93	3,682	21.00
22.00	Skilled Nursing Visit Charges	578,715	77,239	16,168	17,439	689,561	22.00
23.00	Physical Therapy Visits	1,624	121	29	65	1,839	23.00
24.00	Physical Therapy Visit Charges	332,080	24,675	5,935	13,285	375,975	24.00
25.00	Occupational Therapy Visits	350	61	0	20	431	25.00
26.00	Occupational Therapy Visit Charges	72,420	12,597	0	4,140	89,157	26.00
27.00	Speech Pathology Visits	72	8	0	0	80	27.00
28.00	Speech Pathology Visit Charges	15,896	1,732	0	0	17,628	28.00
29.00	Medical Social Service Visits	5	3	0	0	8	29.00
30.00	Medical Social Service Visit Charges	1,495	897	0	0	2,392	30.00
31.00	Home Health Aide Visits	577	111	1	34	723	31.00
32.00	Home Health Aide Visit Charges	48,304	9,304	84	2,856	60,548	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,718	717	116	212	6,763	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,048,910	126,444	22,187	37,720	1,235,261	35.00
36.00	Total Number of Episodes (standard/non outlier)	309		42	16	367	36.00
37.00	Total Number of Outlier Episodes		17		1	18	37.00
38.00	Total Non-Routine Medical Supply Charges	97,322	15,969	4,378	827	118,496	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/25/2020 8:03 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.223842	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		72,236,982	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		340,117,285	6.00
7.00	Medicaid cost (line 1 times line 6)		76,132,533	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)		3,895,551	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)		3,895,551	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	32,463,432	5,105,791	37,569,223
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	7,266,680	5,105,791	12,372,471
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	7,266,680	5,105,791	12,372,471
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		25,162,002	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,106,768	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,702,719	27.01
28.00	Non-Medicare bad debt expense (see instructions)		23,459,283	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		5,847,124	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		18,219,595	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		22,115,146	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0002		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	21,043,102	21,043,102	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,683,288	27,833,528	29,516,816	223,787	4.00
5.01	00550	DATA PROCESSING	3,998,413	9,039,923	13,038,336	-2,235,427	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	877,055	3,087,314	3,964,369	-146,039	5.02
5.03	00570	ADMINISTRATIVE	1,935,289	446,188	2,381,477	-6,779	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,479,684	4,631,454	7,111,138	-319,081	5.04
5.05	00590	OTHER A&G	11,242,551	22,419,203	33,661,754	-12,819,435	5.05
5.06	00592	PATIENT TRANSPORTATION	552,024	69,164	621,188	-21,410	5.06
7.00	00700	OPERATION OF PLANT	3,830,966	9,113,116	12,944,082	4,745,538	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,453,279	1,453,279	0	8.00
9.00	00900	HOUSEKEEPING	4,488,456	1,299,089	5,787,545	-232,982	9.00
10.00	01000	DIETARY	3,342,731	2,730,238	6,072,969	-2,519,147	10.00
11.00	01100	CAFETERIA	255,262	32,837	288,099	2,441,243	11.00
13.00	01300	NURSING ADMINISTRATION	3,220,339	566,870	3,787,209	-53,064	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	619,842	1,331,179	1,951,021	-407,511	14.00
15.00	01500	PHARMACY	0	13,697,152	13,697,152	-7,983,411	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,970,757	854,546	2,825,303	-10,412	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	407,414	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	44,765	44,765	-148	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	222,850	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	31,168	22.00
23.00	02300	PARAMED PROGRAM	471,093	79,108	550,201	261,775	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,703,111	12,212,897	43,916,008	-746,525	30.00
31.00	03100	INTENSIVE CARE UNIT	5,977,237	2,312,643	8,289,880	-719,035	31.00
31.01	03101	NEONATAL ICU	1,560,179	1,187,072	2,747,251	-34,791	31.01
40.00	04000	SUBPROVIDER - I PF	1,214,815	109,242	1,324,057	-16,497	40.00
41.00	04100	SUBPROVIDER - I RF	2,666,443	404,363	3,070,806	-55,300	41.00
43.00	04300	NURSERY	1,236,156	358,778	1,594,934	-102,808	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,906,082	16,401,878	20,307,960	-13,509,602	50.00
50.01	05001	ENDOSCOPY	1,155,257	1,786,400	2,941,657	-349,421	50.01
51.00	05100	RECOVERY ROOM	1,041,229	127,170	1,168,399	-12,422	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,951,108	508,966	3,460,074	-195,476	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,384,403	2,521,071	4,905,474	-904,713	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	1,213,446	1,018,976	2,232,422	-519,890	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	467,047	2,321,213	2,788,260	-755,291	55.00
55.01	05501	INFUSION CENTER	8,099	7,134	15,233	-5,154	55.01
56.00	05600	RADIOISOTOPE	513,737	1,631,320	2,145,057	-240,725	56.00
57.00	05700	CT SCAN	1,063,711	1,447,805	2,511,516	-541,044	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	406,713	1,346,468	1,753,181	-743,988	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,119,463	5,608,287	7,727,750	-4,340,067	59.00
60.00	06000	LABORATORY	3,550,720	6,141,160	9,691,880	-75,304	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,145,826	343,188	1,489,014	-9,817	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,445,723	1,102,452	3,548,175	-331,816	65.00
66.00	06600	PHYSICAL THERAPY	1,379,574	159,187	1,538,761	-2,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,183,313	96,968	1,280,281	-442	67.00
68.00	06800	SPEECH PATHOLOGY	466,863	52,054	518,917	-2,005	68.00
69.00	06900	ELECTROCARDIOLOGY	719,542	287,410	1,006,952	-189,037	69.00
69.01	06901	CARDIAC REHAB	411,500	387,502	799,002	-214,827	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	880,816	9,582,511	10,463,327	-9,317,758	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,776,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,045,657	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	405,415	1,509,719	1,915,134	13,956,320	73.00
74.00	07400	RENAL DIALYSIS	164	2,076,105	2,076,269	-1,634	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,503,590	2,303,267	4,806,857	-290,962	90.00
91.00	09100	EMERGENCY	7,434,374	4,364,333	11,798,707	-1,096,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,123,190	394,239	2,517,429	-17,524	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,206,596	178,840,731	306,047,327	3,057,493	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,164	1,164	-1,153	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,809,167	13,904,172	35,713,339	-1,062,187	34,651,152	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	2,636,108	2,636,108	-1,994,153	641,955	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	166,767	47,569	214,336	0	214,336	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	149,182,530	195,429,744	344,612,274	0	344,612,274	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,844,563	19,198,539	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,854,798	31,595,401	4.00
5.01	00550	DATA PROCESSING	-199,492	10,603,417	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	3,818,330	5.02
5.03	00570	ADMITTING	0	2,374,698	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-71,234	6,720,823	5.04
5.05	00590	OTHER A&G	-336,279	20,506,040	5.05
5.06	00592	PATIENT TRANSPORTATION	0	599,778	5.06
7.00	00700	OPERATION OF PLANT	0	17,689,620	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,453,279	8.00
9.00	00900	HOUSEKEEPING	-180	5,554,383	9.00
10.00	01000	DIETARY	-21,538	3,532,284	10.00
11.00	01100	CAFETERIA	-861,149	1,868,193	11.00
13.00	01300	NURSING ADMINISTRATION	-2,828	3,731,317	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,543,510	14.00
15.00	01500	PHARMACY	-62,624	5,651,117	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-110,736	2,704,155	16.00
17.00	01700	SOCIAL SERVICE	0	407,414	17.00
17.01	01701	STAFF EDUCATION	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	44,617	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	222,850	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	31,168	22.00
23.00	02300	PARAMED ED PROGRAM	-285,312	526,664	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-9,353,271	33,816,212	30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,570,845	31.00
31.01	03101	NEONATAL ICU	-1,010,425	1,702,035	31.01
40.00	04000	SUBPROVIDER - I PF	0	1,307,560	40.00
41.00	04100	SUBPROVIDER - I RF	0	3,015,506	41.00
43.00	04300	NURSERY	0	1,492,126	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,798,358	50.00
50.01	05001	ENDOSCOPY	0	2,592,236	50.01
51.00	05100	RECOVERY ROOM	0	1,155,977	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,264,598	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,000,761	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	-5,670	1,706,862	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-9,671	2,023,298	55.00
55.01	05501	INFUSION CENTER	0	10,079	55.01
56.00	05600	RADIOISOTOPE	0	1,904,332	56.00
57.00	05700	CT SCAN	-8,679	1,961,793	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,009,193	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,387,683	59.00
60.00	06000	LABORATORY	-65,356	9,551,220	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	-72,100	1,407,097	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,216,359	65.00
66.00	06600	PHYSICAL THERAPY	0	1,536,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,279,839	67.00
68.00	06800	SPEECH PATHOLOGY	0	516,912	68.00
69.00	06900	ELECTROCARDIOLOGY	0	817,915	69.00
69.01	06901	CARDIAC REHAB	-119,388	464,787	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-663	1,144,906	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,776,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,045,657	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-331,683	15,539,771	73.00
74.00	07400	RENAL DIALYSIS	0	2,074,635	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-450	4,515,445	90.00
91.00	09100	EMERGENCY	-380,925	10,320,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	2,499,905	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,299,418	295,805,402	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11	190.00
191.00	19100	RESEARCH	0	0	191.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	34,651,152	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	641,955	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	214,336	192.02
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,299,418	331,312,856	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	1,290,602	1,154,308	1.00	
	O		1,290,602	1,154,308		
B - CLINICAL TRAINING COST						
1.00	PARAMED ED PROGRAM	23.00	266,266	0	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	
	O		266,266	0		
C - SOCIAL WORKERS						
1.00	SOCIAL SERVICE	17.00	407,414	0	1.00	
	O		407,414	0		
E - RESIDENTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	222,850	1.00	
2.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	31,168	2.00	
	O		0	254,018		
F - MED SUPPLY						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,776,424	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,045,657	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
37.00		0.00	0	0	37.00	
38.00		0.00	0	0	38.00	
39.00		0.00	0	0	39.00	
40.00		0.00	0	0	40.00	
41.00		0.00	0	0	41.00	
	O		0	21,822,081		
G - LIGHT DUTY						
1.00	HOUSEKEEPING	9.00	126	0	1.00	
2.00	DIETARY	10.00	4,717	0	2.00	
3.00	NURSING ADMINISTRATION	13.00	2,088	0	3.00	
4.00	ADULTS & PEDIATRICS	30.00	12,194	0	4.00	
5.00	OPERATING ROOM	50.00	31,540	0	5.00	
6.00	DELIVERY ROOM & LABOR ROOM	52.00	699	0	6.00	
7.00	RESPIRATORY THERAPY	65.00	3,736	0	7.00	
	O		55,100	0		

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,116,715	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
	0		0	3,116,715	
I - CORPORATE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,140,067	1.00
2.00	OPERATION OF PLANT	7.00	0	4,387,660	2.00
	0		0	10,527,727	
J - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,212,529	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	14,212,529	
K - PHYSICIAN RECLASS					
1.00	OTHER A&G	5.05	0	39,950	1.00
2.00	CLINIC	90.00	0	48,065	2.00
	0		0	88,015	
L - PSTD RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	288,714	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	0		0	288,714	
M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,786,320	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

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48.00		0.00	0	0		48.00
49.00		0.00	0	0		49.00
0			0	11,786,320		
N - DEPT 9101 RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	252,081	21,353		1.00
0			252,081	21,353		
O - UTILITIES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	802,639		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
0			0	802,639		
P - C SECTION RECLASS						
1.00	OPERATING ROOM	50.00	40,437	0		1.00
	TOTALS		40,437	0		
500.00	Grand Total: Increases		2,311,900	64,074,419		500.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
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Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - CAFETERIA							
1.00	DIETARY	10.00	1,290,602	1,154,308	0		1.00
	O		1,290,602	1,154,308			
B - CLINICAL TRAINING COST							
1.00	ADULTS & PEDIATRICS	30.00	13,148	0	0		1.00
2.00	OPERATING ROOM	50.00	11,488	0	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	7,424	0	0		3.00
4.00	LABORATORY	60.00	12,607	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	16,834	0	0		5.00
6.00	EMERGENCY	91.00	204,765	0	0		6.00
	O		266,266	0			
C - SOCIAL WORKERS							
1.00	OTHER A&G	5.05	407,414	0	0		1.00
	O		407,414	0			
E - RESIDENTS							
1.00	EMERGENCY	91.00	0	254,018	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	254,018			
F - MED SUPPLY							
1.00	PURCHASING RECEIVING AND STORES	5.02	0	105,684	0		1.00
2.00	ADMINISTRATIVE	5.03	0	20	0		2.00
3.00	OTHER A&G	5.05	0	223	0		3.00
4.00	OPERATION OF PLANT	7.00	0	34	0		4.00
5.00	HOUSEKEEPING	9.00	0	4,127	0		5.00
6.00	DIETARY	10.00	0	18	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	693	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	127,640	0		8.00
9.00	PHARMACY	15.00	0	88,800	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	26	0		10.00
11.00	MEDICAL EDUCATION	17.02	0	148	0		11.00
12.00	PARAMEDICAL PROGRAM	23.00	0	171	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	484,371	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	153,328	0		14.00
15.00	NEONATAL ICU	31.01	0	509	0		15.00
16.00	SUBPROVIDER - IRF	41.00	0	39,640	0		16.00
17.00	NURSERY	43.00	0	32,410	0		17.00
18.00	OPERATING ROOM	50.00	0	12,709,157	0		18.00
19.00	ENDOSCOPY	50.01	0	272,363	0		19.00
20.00	RECOVERY ROOM	51.00	0	9,334	0		20.00
21.00	DELIVERY ROOM & LABOR ROOM	52.00	0	33,614	0		21.00
22.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,644	0		22.00
23.00	RADIOLOGY - ULTRASOUND	54.01	0	33,553	0		23.00
24.00	RADIOLOGY-THERAPEUTIC	55.00	0	16,857	0		24.00
25.00	RADIOISOTOPE	56.00	0	419	0		25.00
26.00	CT SCAN	57.00	0	45,376	0		26.00
27.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	247	0		27.00
28.00	CARDIAC CATHETERIZATION	59.00	0	3,869,601	0		28.00
29.00	LABORATORY	60.00	0	15,533	0		29.00
30.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	118	0		30.00
31.00	RESPIRATORY THERAPY	65.00	0	246,385	0		31.00
32.00	PHYSICAL THERAPY	66.00	0	419	0		32.00
33.00	ELECTROCARDIOLOGY	69.00	0	8,191	0		33.00
34.00	CARDIAC REHAB	69.01	0	933	0		34.00
35.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,742,005	0		35.00
36.00	DRUGS CHARGED TO PATIENTS	73.00	0	228,282	0		36.00
37.00	RENAL DIALYSIS	74.00	0	1,634	0		37.00
38.00	CLINIC	90.00	0	168,821	0		38.00
39.00	EMERGENCY	91.00	0	285,770	0		39.00
40.00	HOME HEALTH AGENCY	101.00	0	14,971	0		40.00
41.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	78,012	0		41.00
	O		0	21,822,081			
G - LIGHT DUTY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	55,100	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	O		55,100	0			

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
H - INTEREST EXPENSE						
1.00	OTHER A&G	5.05	0	1,585,803	11	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	115,716	0	2.00
3.00	RADIOLOGY - ULTRASOUND	54.01	0	57,858	0	3.00
4.00	CT SCAN	57.00	0	57,858	0	4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	57,858	0	5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	191	0	6.00
7.00	OTHER NON-REIMBURSABLE	192.01	0	1,241,431	0	7.00
	O		0	3,116,715		
I - CORPORATE EXPENSE						
1.00	OTHER A&G	5.05	0	10,527,727	9	1.00
2.00		0.00	0	0	0	2.00
	O		0	10,527,727		
J - DRUG EXPENSE						
1.00	PHARMACY	15.00	0	7,749,771	0	1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,457,604	0	2.00
3.00	INFUSION CENTER	55.01	0	5,154	0	3.00
	O		0	14,212,529		
K - PHYSICIAN RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	88,015	0	1.00
2.00		0.00	0	0	0	2.00
	O		0	88,015		
L - PSTD RECLASS						
1.00	PURCHASING RECEIVING AND STORES	5.02	3,299	0	0	1.00
2.00	ADMINISTRATIVE	5.03	5,120	0	0	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	3,220	0	0	3.00
4.00	OTHER A&G	5.05	28,533	0	0	4.00
5.00	PATIENT TRANSPORTATION	5.06	1,655	0	0	5.00
6.00	OPERATION OF PLANT	7.00	9,268	0	0	6.00
7.00	HOUSEKEEPING	9.00	27,249	0	0	7.00
8.00	DIETARY	10.00	5,787	0	0	8.00
9.00	CAFETERIA	11.00	3,116	0	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	3,882	0	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	31,693	0	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	17,734	0	0	12.00
13.00	SUBPROVIDER - IPF	40.00	6,147	0	0	13.00
14.00	SUBPROVIDER - IRF	41.00	6,468	0	0	14.00
15.00	NURSERY	43.00	4,122	0	0	15.00
16.00	OPERATING ROOM	50.00	6,418	0	0	16.00
17.00	ENDOSCOPY	50.01	3,240	0	0	17.00
18.00	RECOVERY ROOM	51.00	1,811	0	0	18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	7,715	0	0	19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	8,145	0	0	20.00
21.00	RADIOLOGY - ULTRASOUND	54.01	1,524	0	0	21.00
22.00	CT SCAN	57.00	6,286	0	0	22.00
23.00	CARDIAC CATHETERIZATION	59.00	9,090	0	0	23.00
24.00	LABORATORY	60.00	3,268	0	0	24.00
25.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	918	0	0	25.00
26.00	RESPIRATORY THERAPY	65.00	922	0	0	26.00
27.00	CLINIC	90.00	4,776	0	0	27.00
28.00	EMERGENCY	91.00	6,500	0	0	28.00
29.00	HOME HEALTH AGENCY	101.00	1,419	0	0	29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	69,389	0	0	30.00
	O		288,714	0		
M - DEPRECIATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,827	9	1.00
2.00	DATA PROCESSING	5.01	0	2,072,072	0	2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	0	37,056	0	3.00
4.00	ADMINISTRATIVE	5.03	0	1,639	0	4.00
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	4,374	0	5.00
6.00	OTHER A&G	5.05	0	309,685	0	6.00
7.00	PATIENT TRANSPORTATION	5.06	0	19,755	0	7.00
8.00	OPERATION OF PLANT	7.00	0	435,459	0	8.00
9.00	HOUSEKEEPING	9.00	0	63,831	0	9.00
10.00	DIETARY	10.00	0	73,149	0	10.00
11.00	CAFETERIA	11.00	0	551	0	11.00
12.00	NURSING ADMINISTRATION	13.00	0	54,459	0	12.00
13.00	CENTRAL SERVICES & SUPPLY	14.00	0	279,871	0	13.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
6/25/2020 8:03 am

Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
14.00	PHARMACY	15.00	0	144,840	0		14.00	
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,504	0		15.00	
16.00	PARAMED ED PROGRAM	23.00	0	4,320	0		16.00	
17.00	ADULTS & PEDIATRICS	30.00	0	229,507	0		17.00	
18.00	INTENSIVE CARE UNIT	31.00	0	547,973	0		18.00	
19.00	NEONATAL ICU	31.01	0	34,282	0		19.00	
20.00	SUBPROVIDER - IPF	40.00	0	10,350	0		20.00	
21.00	SUBPROVIDER - IRF	41.00	0	9,192	0		21.00	
22.00	NURSERY	43.00	0	66,276	0		22.00	
23.00	OPERATING ROOM	50.00	0	854,516	0		23.00	
24.00	ENDOSCOPY	50.01	0	73,818	0		24.00	
25.00	RECOVERY ROOM	51.00	0	1,277	0		25.00	
26.00	DELIVERY ROOM & LABOR ROOM	52.00	0	114,409	0		26.00	
27.00	RADIOLOGY-DIAGNOSTIC	54.00	0	778,208	0		27.00	
28.00	RADIOLOGY - ULTRASOUND	54.01	0	426,955	0		28.00	
29.00	RADIOLOGY-THERAPEUTIC	55.00	0	738,434	0		29.00	
30.00	RADIOISOTOPE	56.00	0	240,306	0		30.00	
31.00	CT SCAN	57.00	0	431,524	0		31.00	
32.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	685,883	0		32.00	
33.00	CARDIAC CATHETERIZATION	59.00	0	453,952	0		33.00	
34.00	LABORATORY	60.00	0	43,896	0		34.00	
35.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	8,781	0		35.00	
36.00	RESPIRATORY THERAPY	65.00	0	71,411	0		36.00	
37.00	PHYSICAL THERAPY	66.00	0	1,733	0		37.00	
38.00	OCCUPATIONAL THERAPY	67.00	0	442	0		38.00	
39.00	SPEECH PATHOLOGY	68.00	0	2,005	0		39.00	
40.00	ELECTROCARDIOLOGY	69.00	0	180,846	0		40.00	
41.00	CARDIAC REHAB	69.01	0	167,338	0		41.00	
42.00	ELECTROENCEPHALOGRAPHY	70.00	0	118,149	0		42.00	
43.00	DRUGS CHARGED TO PATIENTS	73.00	0	27,927	0		43.00	
44.00	CLINIC	90.00	0	165,430	0		44.00	
45.00	EMERGENCY	91.00	0	345,859	0		45.00	
46.00	HOME HEALTH AGENCY	101.00	0	1,134	0		46.00	
47.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,153	0		47.00	
48.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	754,789	0		48.00	
49.00	OTHER NON-REIMBURSABLE	192.01	0	681,173	0		49.00	
	0		0	11,786,320				
N - DEPT 9101 RECLASS								
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	252,081	21,353	0		1.00	
	0		252,081	21,353				
O - UTILITIES RECLASS								
1.00	DATA PROCESSING	5.01	0	163,355	0		1.00	
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	38,053	0		2.00	
3.00	HOUSEKEEPING	9.00	0	137,901	0		3.00	
4.00	CARDIAC REHAB	69.01	0	46,556	0		4.00	
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	345,225	0		5.00	
6.00	OTHER NON-REIMBURSABLE	192.01	0	71,549	0		6.00	
	0		0	802,639				
P - C SECTION RECLASS								
1.00	DELIVERY ROOM & LABOR ROOM	52.00	40,437	0	0		1.00	
	TOTALS		40,437	0				
500.00	Grand Total: Decreases		2,600,614	63,785,705			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part I
Date/Time Prepared:
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		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,373,674	0	0	0	1.00	
2.00	Land Improvements	6,708,539	136,373	0	136,373	2.00	
3.00	Buildings and Fixtures	270,530,443	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	5.00	
6.00	Movable Equipment	203,218,657	8,635,406	0	8,635,406	6.00	
7.00	HIT designated Assets	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	485,831,313	8,771,779	0	8,771,779	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	485,831,313	8,771,779	0	8,771,779	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,373,674	0			1.00	
2.00	Land Improvements	6,844,912	0			2.00	
3.00	Buildings and Fixtures	270,428,699	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	211,854,063	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	494,501,348	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	494,501,348	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part II
Date/Time Prepared:
6/25/2020 8:03 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part III
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	494,501,348	0	494,501,348	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	494,501,348	0	494,501,348	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	17,956,917	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	17,956,917	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,241,622	0	0	0	19,198,539	1.00
3.00	Total (sum of lines 1-2)	1,241,622	0	0	0	19,198,539	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,875,093	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-10,791,528			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	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-861,149	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-110,736	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-21,538	DIETARY	10.00	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	A	30,530	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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

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		
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 DATA PROCESSING OTHER INCOME	B	-199,492		DATA PROCESSING	5.01	0	33.00
33.01 CASH, A/R, COLLECTIONS OTHER INCOME	B	-33,228		CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.01
33.02 A&G OTHER INCOME	B	-307,039		OTHER A&G	5.05	0	33.02
34.00 ENVIRONMENTAL SERVICES OTHER INCOME	B	-180		HOUSEKEEPING	9.00	0	34.00
35.00 NURSING ADMIN OTHER INCOME	B	-2,828		NURSING ADMINISTRATION	13.00	0	35.00
36.00 PHARMACY	B	-62,624		PHARMACY	15.00	0	36.00
37.00 PARAMED ED PROGRAM OTHER INCOME	B	-92,472		PARAMED ED PROGRAM	23.00	0	37.00
38.00 ADULTS & PEDI OTHER INCOME	B	-5,148		ADULTS & PEDIATRICS	30.00	0	38.00
40.00 RADIOLOGY - THERAPEUTIC	B	-9,671		RADIOLOGY-THERAPEUTIC	55.00	0	40.00
40.01 LAB OTHER INCOME	B	-65,356		LABORATORY	60.00	0	40.01
40.02 BLOOD OTHER INCOME	B	-72,100		WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	40.02
40.03 CARDIAC REHAB OTHER INCOME	B	-119,388		CARDIAC REHAB	69.01	0	40.03
40.04 ELECTROCEPHALOGRAPHY OTHER INCOME	B	-663		ELECTROENCEPHALOGRAPHY	70.00	0	40.04
40.05 CLINIC OTHER INCOME	B	-450		CLINIC	90.00	0	40.05
40.06 EMERGENCY ROOM	B	-300		EMERGENCY	91.00	0	40.06
40.07 EMT OFFSET	B	-43,474		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.07
40.08 EMT OFFSET	B	-192,840		PARAMED ED PROGRAM	23.00	0	40.08
40.09 DUES/LOBBYING	A	-29,240		OTHER A&G	5.05	0	40.09
41.00 RX PROGRAM	A	-331,683		DRUGS CHARGED TO PATIENTS	73.00	0	41.00
42.00 PENSION ADJUSTMENT	A	1,898,272		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,299,418					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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0002

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

Worksheet A-8-2
Date/Time Prepared:
6/25/2020 8:03 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	CASHIERING/ACCOUNTS RECEIVABLE	38,006	38,006	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	9,376,086	9,335,646	40,440	211,500	275	2.00
3.00	31.01	NEONATAL ICU	1,010,425	1,010,425	0	0	0	3.00
4.00	54.01	RADIOLOGY - ULTRASOUND	5,670	5,670	0	0	0	4.00
5.00	57.00	CT SCAN	8,679	8,679	0	0	0	5.00
6.00	91.00	EMERGENCY	380,625	380,625	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			10,819,491	10,779,051	40,440		275	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	5.04	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	27,963	1,398	0	0	0	2.00
3.00	31.01	NEONATAL ICU	0	0	0	0	0	3.00
4.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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			27,963	1,398	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	5.04	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	38,006		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	27,963	12,477	9,348,123		2.00
3.00	31.01	NEONATAL ICU	0	0	0	1,010,425		3.00
4.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	5,670		4.00
5.00	57.00	CT SCAN	0	0	0	8,679		5.00
6.00	91.00	EMERGENCY	0	0	0	380,625		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	27,963	12,477	10,791,528		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPI TAL	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
		RELATED COSTS BLDG & FIXT				
	0	1.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	19,198,539	19,198,539				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	31,595,401	80,408	31,675,809			4.00
5.01 00550 DATA PROCESSING	10,603,417	125,119	860,031	11,588,567		5.01
5.02 00560 PURCHASING RECEIVING AND STORES	3,818,330	99,823	187,939	0	4,106,092	5.02
5.03 00570 ADMITTING	2,374,698	132,294	415,166	0	4,776	5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	6,720,823	417,236	478,449	0	1,689	5.04
5.05 00590 OTHER A&G	20,506,040	1,355,738	2,324,425	11,588,567	5,013	5.05
5.06 00592 PATIENT TRANSPORTATION	599,778	0	118,381	0	452	5.06
7.00 00700 OPERATION OF PLANT	17,689,620	4,075,275	822,020	0	53,039	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1,453,279	242,682	0	0	39	8.00
9.00 00900 HOUSEKEEPING	5,554,383	280,939	959,601	0	41,320	9.00
10.00 01000 DIETARY	3,532,284	256,610	441,168	0	68,498	10.00
11.00 01100 CAFETERIA	1,868,193	179,401	331,834	0	113	11.00
13.00 01300 NURSING ADMINISTRATION	3,731,317	86,453	693,121	0	2,658	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	1,543,510	487,992	133,324	0	0	14.00
15.00 01500 PHARMACY	5,651,117	258,094	0	0	14,383	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2,704,155	153,941	423,061	0	695	16.00
17.00 01700 SOCIAL SERVICE	407,414	22,178	87,632	0	0	17.00
17.01 01701 STAFF EDUCATION	0	151,763	0	0	0	17.01
17.02 01702 MEDICAL EDUCATION	44,617	5,092	0	0	120	17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	222,850	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	31,168	60,817	0	0	0	22.00
23.00 02300 PARAMED ED PROGRAM	526,664	45,800	158,601	0	739	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	33,816,212	4,264,357	6,812,100	0	238,462	30.00
31.00 03100 INTENSIVE CARE UNIT	7,570,845	270,442	1,281,847	0	88,456	31.00
31.01 03101 NEONATAL ICU	1,702,035	30,742	335,584	0	1,301	31.01
40.00 04000 SUBPROVIDER - I/PF	1,307,560	54,078	259,976	0	102	40.00
41.00 04100 SUBPROVIDER - I/RF	3,015,506	425,364	572,142	0	10,435	41.00
43.00 04300 NURSERY	1,492,126	332,525	265,002	0	16,679	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	6,798,358	812,076	851,801	0	132,830	50.00
50.01 05001 ENDOSCOPY	2,592,236	0	247,791	0	72,542	50.01
51.00 05100 RECOVERY ROOM	1,155,977	198,039	223,572	0	3,991	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,264,598	95,344	624,556	0	13,014	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,000,761	722,382	511,116	0	16,520	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	1,706,862	68,809	260,676	0	13,897	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	2,023,298	183,594	100,459	0	3,235	55.00
55.01 05501 INFUSION CENTER	10,079	4,901	1,742	0	83	55.01
56.00 05600 RADIOISOTOPE	1,904,332	123,118	110,501	0	116,119	56.00
57.00 05700 CT SCAN	1,961,793	116,583	227,445	0	31,876	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,009,193	57,250	87,481	0	8,937	58.00
59.00 05900 CARDIAC CATHETERIZATION	3,387,683	109,367	452,330	0	55,903	59.00
60.00 06000 LABORATORY	9,551,220	320,191	760,320	0	320,236	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,407,097	5,242	246,262	0	25,403	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	3,216,359	105,732	523,042	0	62,563	65.00
66.00 06600 PHYSICAL THERAPY	1,536,609	167,052	296,737	0	746	66.00
67.00 06700 OCCUPATIONAL THERAPY	1,279,839	143,567	254,522	0	757	67.00
68.00 06800 SPEECH PATHOLOGY	516,912	24,452	100,419	0	1,212	68.00
69.00 06900 ELECTROCARDIOLOGY	817,915	0	154,768	0	1,584	69.00
69.01 06901 CARDIAC REHAB	464,787	0	88,511	0	261	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	1,144,906	0	189,457	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,776,424	0	0	0	1,273,208	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10,045,657	0	0	0	1,086,096	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	15,539,771	22,628	87,202	0	50,662	73.00
74.00 07400 RENAL DIALYSIS	2,074,635	59,673	35	0	2,998	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	4,515,445	1,037,182	537,477	0	7,819	90.00
91.00 09100 EMERGENCY	10,320,870	368,455	1,553,640	0	211,188	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	2,499,905	0	456,378	0	11,122	101.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
		BLDG & FIXT					
	0	1.00		4.00	5.01	5.02	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	295,805,402	18,640,800	26,909,644	11,588,567	4,073,771	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11	24,520	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	34,651,152	363,662	4,730,295	0	32,272	192.00
192.01	19201 OTHER NON-REIMBURSABLE	641,955	47,066	0	0	3	192.01
192.02	19202 FAMILY HEALTH/GARY COMM HEALTH	214,336	122,491	35,870	0	46	192.02
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
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)	331,312,856	19,198,539	31,675,809	11,588,567	4,106,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description			ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	
			5.03	5.04	5A.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMINISTRATIVE	2,926,934					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,618,197				5.04
5.05	00590	OTHER A&G	0	0	35,779,783	35,779,783		5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	718,611	87,002	805,613	5.06
7.00	00700	OPERATION OF PLANT	0	0	22,639,954	2,740,997	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,696,000	205,333	0	8.00
9.00	00900	HOUSEKEEPING	0	0	6,836,243	827,657	0	9.00
10.00	01000	DIETARY	0	0	4,298,560	520,422	0	10.00
11.00	01100	CAFETERIA	0	0	2,379,541	288,089	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,513,549	546,451	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,164,826	262,093	18	14.00
15.00	01500	PHARMACY	0	0	5,923,594	717,164	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,281,852	397,331	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	517,224	62,620	0	17.00
17.01	01701	STAFF EDUCATION	0	0	151,763	18,374	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	49,829	6,033	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	222,850	26,980	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	91,985	11,137	0	22.00
23.00	02300	PARAMED PROGRAM	0	0	731,804	88,599	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	247,577	644,323	46,023,031	5,571,848	315,477	30.00
31.00	03100	INTENSIVE CARE UNIT	39,998	104,095	9,355,683	1,132,683	4,260	31.00
31.01	03101	NEONATAL ICU	11,360	29,564	2,110,586	255,527	18	31.01
40.00	04000	SUBPROVIDER - I/PF	11,484	29,886	1,663,086	201,348	0	40.00
41.00	04100	SUBPROVIDER - I/RF	16,634	43,289	4,083,370	494,370	7,186	41.00
43.00	04300	NURSERY	5,266	13,705	2,125,303	257,308	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	330,770	860,832	9,786,667	1,184,862	55	50.00
50.01	05001	ENDOSCOPY	43,624	113,531	3,069,724	371,648	18,011	50.01
51.00	05100	RECOVERY ROOM	23,300	60,639	1,665,518	201,643	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,165	26,454	4,034,131	488,408	7,570	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,992	247,218	5,592,989	677,138	80,272	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	42,718	111,173	2,204,135	266,852	83,710	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	48,192	125,421	2,484,199	300,759	4,736	55.00
55.01	05501	INFUSION CENTER	537	1,398	18,740	2,269	0	55.01
56.00	05600	RADIOISOTOPE	36,097	93,942	2,384,109	288,642	44,013	56.00
57.00	05700	CT SCAN	290,986	757,294	3,385,977	409,937	149,171	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	70,748	184,122	1,417,731	171,643	49,736	58.00
59.00	05900	CARDIAC CATHETERIZATION	159,647	415,483	4,580,413	554,546	25,417	59.00
60.00	06000	LABORATORY	360,901	940,071	12,252,939	1,483,451	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	23,158	60,269	1,767,431	213,981	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	104,883	272,958	4,285,537	518,846	219	65.00
66.00	06600	PHYSICAL THERAPY	18,229	47,442	2,066,815	250,227	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,850	36,046	1,728,581	209,278	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,046	15,734	664,775	80,484	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59,399	154,587	1,188,253	143,861	3,072	69.00
69.01	06901	CARDIAC REHAB	2,088	5,434	561,081	67,930	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	60,543	157,564	1,552,470	187,956	6,235	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,960	304,388	13,470,980	1,630,918	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,824	163,501	11,358,078	1,375,111	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356,653	928,193	16,985,109	2,056,370	0	73.00
74.00	07400	RENAL DIALYSIS	20,047	52,173	2,209,561	267,509	55	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	59,630	155,188	6,312,741	764,277	311	90.00
91.00	09100	EMERGENCY	169,452	441,001	13,064,606	1,581,719	6,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	8,176	21,279	2,996,860	362,827	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,926,934	7,618,197	290,449,177	30,832,458	805,613	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24,531	2,970	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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Cost Center Description			ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	
			5.03	5.04	5A.04	5.05	5.06	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	39,777,381	4,815,808	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	689,024	83,419	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	372,743	45,128	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,926,934	7,618,197	331,312,856	35,779,783	805,613	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT	25,380,951					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	477,013	2,378,346				8.00
9.00	00900	HOUSEKEEPING	552,211	0	8,216,111			9.00
10.00	01000	DIETARY	504,390	0	170,178	5,493,550		10.00
11.00	01100	CAFETERIA	352,628	0	118,974	0	3,139,232	11.00
13.00	01300	NURSING ADMINISTRATION	169,932	0	57,334	0	80,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	959,191	4,051	323,625	0	40,654	14.00
15.00	01500	PHARMACY	507,306	0	171,162	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	302,586	0	102,090	0	101,146	16.00
17.00	01700	SOCIAL SERVICE	43,594	0	14,708	0	16,867	17.00
17.01	01701	STAFF EDUCATION	298,304	0	100,646	0	0	17.01
17.02	01702	MEDICAL EDUCATION	10,009	0	3,377	0	0	17.02
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	119,541	0	40,332	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	90,024	0	30,373	0	35,683	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,381,967	1,009,257	2,828,022	4,338,878	1,082,268	30.00
31.00	03100	INTENSIVE CARE UNIT	531,579	165,394	179,351	211,570	173,175	31.00
31.01	03101	NEONATAL ICU	60,426	0	20,387	0	43,183	31.01
40.00	04000	SUBPROVIDER - IPF	106,294	0	35,863	147,517	37,881	40.00
41.00	04100	SUBPROVIDER - IRF	836,091	163,156	282,092	481,959	94,525	41.00
43.00	04300	NURSERY	653,608	34,192	220,523	0	34,727	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,596,208	254,223	538,550	0	147,385	50.00
50.01	05001	ENDOSCOPY	0	45,163	0	0	38,178	50.01
51.00	05100	RECOVERY ROOM	389,264	15,770	131,335	0	28,154	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	187,407	34,544	63,230	139,642	94,830	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,419,907	63,622	479,067	0	98,566	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	135,250	17,674	45,632	0	39,073	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	360,871	13,696	121,755	0	15,169	55.00
55.01	05501	INFUSION CENTER	9,634	0	3,250	0	293	55.01
56.00	05600	RADIOISOTOPE	241,999	15,688	81,649	0	14,593	56.00
57.00	05700	CT SCAN	229,154	21,586	77,315	0	40,706	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	112,530	9,318	37,967	0	15,062	58.00
59.00	05900	CARDIAC CATHETERIZATION	214,970	59,875	72,530	0	60,149	59.00
60.00	06000	LABORATORY	629,363	0	212,343	0	138,024	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,303	0	3,476	0	73,114	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	207,825	0	70,119	0	89,565	65.00
66.00	06600	PHYSICAL THERAPY	328,356	755	110,785	0	41,116	66.00
67.00	06700	OCCUPATIONAL THERAPY	282,194	4,085	95,210	0	35,833	67.00
68.00	06800	SPEECH PATHOLOGY	48,063	0	16,216	0	12,445	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,552	0	0	27,537	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	14,802	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,888	0	0	28,738	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,477	0	15,006	0	12,364	73.00
74.00	07400	RENAL DIALYSIS	117,293	31,135	39,574	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,038,672	90,105	687,835	0	79,170	90.00
91.00	09100	EMERGENCY	724,230	314,617	244,351	173,984	253,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,284,664	2,378,346	7,846,232	5,493,550	3,139,232	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,196	0	16,261	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	714,811	0	241,172	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
192.01	19201	OTHER NON-REIMBURSABLE	92,512	0	31,213	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	240,768	0	81,233	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,380,951	2,378,346	8,216,111	5,493,550	3,139,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part I Date/Time Prepared: 6/25/2020 8:03 am	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
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	5,368,036					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,754,458				14.00
15.00	01500	PHARMACY	0	0	7,319,226			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,185,005		16.00
17.00	01700	SOCIAL SERVICE	43,522	0	0	0	698,535	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	92,076	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,792,641	0	0	353,912	557,830	30.00
31.00	03100	INTENSIVE CARE UNIT	446,855	0	0	57,177	0	31.00
31.01	03101	NEONATAL ICU	111,428	0	0	16,239	0	31.01
40.00	04000	SUBPROVIDER - IPF	97,747	0	0	16,416	0	40.00
41.00	04100	SUBPROVIDER - IRF	243,908	0	0	23,778	111,766	41.00
43.00	04300	NURSERY	89,607	0	0	7,528	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	380,306	0	0	472,835	0	50.00
50.01	05001	ENDOSCOPY	98,513	0	0	62,360	0	50.01
51.00	05100	RECOVERY ROOM	72,647	0	0	33,307	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	244,696	0	0	14,531	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	135,791	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	61,065	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	68,891	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	768	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	51,600	0	56.00
57.00	05700	CT SCAN	0	0	0	415,964	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	101,134	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	228,215	0	59.00
60.00	06000	LABORATORY	0	0	589,366	516,863	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	33,104	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	149,930	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,059	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	19,799	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,642	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	84,911	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	2,985	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	86,546	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,026,113	0	167,194	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,728,345	0	89,807	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,610,619	509,835	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	28,658	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	85,241	0	90.00
91.00	09100	EMERGENCY	654,090	0	0	242,232	28,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	13,872	11,688	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,368,036	3,754,458	7,213,857	4,185,005	698,535	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

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	105,369	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,368,036	3,754,458	7,319,226	4,185,005	698,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00	
			SERVICES-SALARY & FRINGES 21.00	SERVICES-OTHER PRGM COSTS 22.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00550 DATA PROCESSING						5.01
5.02 00560 PURCHASING RECEIVING AND STORES						5.02
5.03 00570 ADMITTING						5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 00590 OTHER A&G						5.05
5.06 00592 PATIENT TRANSPORTATION						5.06
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE						17.00
17.01 01701 STAFF EDUCATION	569,087					17.01
17.02 01702 MEDICAL EDUCATION	0	69,248				17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	249,830			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	262,995		22.00
23.00 02300 PARAMED PROGRAM	750	0	0	0	1,069,309	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	259,302	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	48,936	0	0	0	0	31.00
31.01 03101 NEONATAL ICU	4,181	0	0	0	0	31.01
40.00 04000 SUBPROVIDER - I PF	4,503	0	0	4,503	0	40.00
41.00 04100 SUBPROVIDER - I RF	24,600	0	0	0	0	41.00
43.00 04300 NURSERY	12,780	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	35,121	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	10,980	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	4,350	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	25,086	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,808	0	0	9,808	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	2,333	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	1,837	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	0	0	0	0	0	55.01
56.00 05600 RADIOISOTOPE	42	0	0	0	0	56.00
57.00 05700 CT SCAN	4,719	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	285	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	20,662	0	0	0	0	59.00
60.00 06000 LABORATORY	860	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	607	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	11,661	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	470	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	486	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	433	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	676	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	723	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	90	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	1,827	0	0	0	0	90.00
91.00 09100 EMERGENCY	58,407	69,248	249,830	262,995	1,069,309	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	11,624	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	558,139	69,248	249,830	262,995	1,069,309	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
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Cost Center Description	STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00	
			SERVICES-SALARY & FRINGES 21.00	SERVICES-OTHER PRGM COSTS 22.00		
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10,906	0	0	0	0	192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	42	0	0	0	0	192.02
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments			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)	569,087	69,248	249,830	262,995	1,069,309	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00570				5.03
5.04	00580				5.04
5.05	00590				5.05
5.06	00592				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
17.02	01702				17.02
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	73,514,433	0	73,514,433	30.00
31.00	03100	12,306,663	0	12,306,663	31.00
31.01	03101	2,621,975	0	2,621,975	31.01
40.00	04000	2,310,655	0	2,310,655	40.00
41.00	04100	6,846,801	0	6,846,801	41.00
43.00	04300	3,435,576	0	3,435,576	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	14,396,212	0	14,396,212	50.00
50.01	05001	3,714,577	0	3,714,577	50.01
51.00	05100	2,541,988	0	2,541,988	51.00
52.00	05200	5,334,075	0	5,334,075	52.00
53.00	05300	0	0	0	53.00
54.00	05400	8,557,160	0	8,557,160	54.00
54.01	05401	2,855,724	0	2,855,724	54.01
55.00	05500	3,371,913	0	3,371,913	55.00
55.01	05501	34,954	0	34,954	55.01
56.00	05600	3,122,335	0	3,122,335	56.00
57.00	05700	4,734,529	0	4,734,529	57.00
58.00	05800	1,915,406	0	1,915,406	58.00
59.00	05900	5,816,777	0	5,816,777	59.00
60.00	06000	15,823,209	0	15,823,209	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	2,102,016	0	2,102,016	62.00
63.00	06300	0	0	0	63.00
64.00	06400	0	0	0	64.00
65.00	06500	5,333,702	0	5,333,702	65.00
66.00	06600	2,824,583	0	2,824,583	66.00
67.00	06700	2,375,466	0	2,375,466	67.00
68.00	06800	831,058	0	831,058	68.00
69.00	06900	1,451,862	0	1,451,862	69.00
69.01	06901	646,798	0	646,798	69.01
70.00	07000	1,869,556	0	1,869,556	70.00
71.00	07100	17,295,205	0	17,295,205	71.00
72.00	07200	14,551,341	0	14,551,341	72.00
73.00	07300	26,233,870	0	26,233,870	73.00
74.00	07400	2,693,785	0	2,693,785	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	10,060,179	0	10,060,179	90.00
91.00	09100	18,998,115	-512,825	18,485,290	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	3,396,871	0	3,396,871	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		283,919,369	-512,825	283,406,544	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	91,958	0	91,958	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,665,447	0	45,665,447	192.00
192.01	19201	OTHER NON-REIMBURSABLE	896,168	0	896,168	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	739,914	0	739,914	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	331,312,856	-512,825	330,800,031	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT					
	0	1.00		2A	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	80,408	80,408	80,408		4.00
5.01 00550	DATA PROCESSING	0	125,119	125,119	2,183	127,302	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	99,823	99,823	477	0	5.02
5.03 00570	ADMINISTRATIVE	0	132,294	132,294	1,054	0	5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	417,236	417,236	1,215	0	5.04
5.05 00590	OTHER A&G	0	1,355,738	1,355,738	5,900	127,302	5.05
5.06 00592	PATIENT TRANSPORTATION	0	0	0	301	0	5.06
7.00 00700	OPERATION OF PLANT	0	4,075,275	4,075,275	2,087	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	242,682	242,682	0	0	8.00
9.00 00900	HOUSEKEEPING	0	280,939	280,939	2,436	0	9.00
10.00 01000	DIETARY	0	256,610	256,610	1,120	0	10.00
11.00 01100	CAFETERIA	0	179,401	179,401	842	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	86,453	86,453	1,759	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	487,992	487,992	338	0	14.00
15.00 01500	PHARMACY	0	258,094	258,094	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	153,941	153,941	1,074	0	16.00
17.00 01700	SOCIAL SERVICE	0	22,178	22,178	222	0	17.00
17.01 01701	STAFF EDUCATION	0	151,763	151,763	0	0	17.01
17.02 01702	MEDICAL EDUCATION	0	5,092	5,092	0	0	17.02
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	60,817	60,817	0	0	22.00
23.00 02300	PARAMED PROGRAM	0	45,800	45,800	403	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	4,264,357	4,264,357	17,294	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	270,442	270,442	3,254	0	31.00
31.01 03101	NEONATAL ICU	0	30,742	30,742	852	0	31.01
40.00 04000	SUBPROVIDER - IPF	0	54,078	54,078	660	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	425,364	425,364	1,452	0	41.00
43.00 04300	NURSERY	0	332,525	332,525	673	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	812,076	812,076	2,162	0	50.00
50.01 05001	ENDOSCOPY	0	0	0	629	0	50.01
51.00 05100	RECOVERY ROOM	0	198,039	198,039	568	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	95,344	95,344	1,585	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	722,382	722,382	1,297	0	54.00
54.01 05401	RADIOLOGY - ULTRASOUND	0	68,809	68,809	662	0	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	183,594	183,594	255	0	55.00
55.01 05501	INFUSION CENTER	0	4,901	4,901	4	0	55.01
56.00 05600	RADIOISOTOPE	0	123,118	123,118	281	0	56.00
57.00 05700	CT SCAN	0	116,583	116,583	577	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	57,250	57,250	222	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	109,367	109,367	1,148	0	59.00
60.00 06000	LABORATORY	0	320,191	320,191	1,930	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,242	5,242	625	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	105,732	105,732	1,328	0	65.00
66.00 06600	PHYSICAL THERAPY	0	167,052	167,052	753	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	143,567	143,567	646	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	24,452	24,452	255	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	393	0	69.00
69.01 06901	CARDIAC REHAB	0	0	0	225	0	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	481	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	22,628	22,628	221	0	73.00
74.00 07400	RENAL DIALYSIS	0	59,673	59,673	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	1,037,182	1,037,182	1,364	0	90.00
91.00 09100	EMERGENCY	0	368,455	368,455	3,944	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	0	1,158	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	18,640,800	18,640,800	68,309	127,302	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING		
			BLDG & FIXT					
	0		1.00	2A	4.00	5.01		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,520	24,520	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	363,662	363,662	12,008	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	47,066	47,066	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	122,491	122,491	91	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	19,198,539	19,198,539	80,408	127,302	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 6/25/2020 8:03 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION	
			5.02	5.03	5.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	100,300					5.02
5.03	00570	ADMINITTING	117	133,465				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	41	0	418,492			5.04
5.05	00590	OTHER A&G	122	0	0	1,489,062		5.05
5.06	00592	PATIENT TRANSPORTATION	11	0	0	3,621	3,933	5.06
7.00	00700	OPERATION OF PLANT	1,296	0	0	114,083	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1	0	0	8,546	0	8.00
9.00	00900	HOUSEKEEPING	1,009	0	0	34,448	0	9.00
10.00	01000	DIETARY	1,673	0	0	21,660	0	10.00
11.00	01100	CAFETERIA	3	0	0	11,991	0	11.00
13.00	01300	NURSING ADMINISTRATION	65	0	0	22,744	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	10,909	0	14.00
15.00	01500	PHARMACY	351	0	0	29,849	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17	0	0	16,537	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,606	0	17.00
17.01	01701	STAFF EDUCATION	0	0	0	765	0	17.01
17.02	01702	MEDICAL EDUCATION	3	0	0	251	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,123	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	464	0	22.00
23.00	02300	PARAMED PROGRAM	18	0	0	3,688	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,825	11,244	35,445	231,779	1,540	30.00
31.00	03100	INTENSIVE CARE UNIT	2,161	1,817	5,726	47,143	21	31.00
31.01	03101	NEONATAL ICU	32	516	1,626	10,635	0	31.01
40.00	04000	SUBPROVIDER - I PF	2	522	1,644	8,380	0	40.00
41.00	04100	SUBPROVIDER - I RF	255	755	2,381	20,576	35	41.00
43.00	04300	NURSERY	407	239	754	10,709	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,245	15,022	47,355	49,315	0	50.00
50.01	05001	ENDOSCOPY	1,772	1,981	6,245	15,468	88	50.01
51.00	05100	RECOVERY ROOM	97	1,058	3,336	8,393	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	318	462	1,455	20,328	37	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404	4,314	13,600	28,183	392	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	339	1,940	6,116	11,107	409	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	79	2,189	6,900	12,518	23	55.00
55.01	05501	INFUSION CENTER	2	24	77	94	0	55.01
56.00	05600	RADIOISOTOPE	2,836	1,639	5,168	12,014	215	56.00
57.00	05700	CT SCAN	779	13,215	41,659	17,062	728	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218	3,213	10,129	7,144	243	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,366	7,250	22,856	23,081	124	59.00
60.00	06000	LABORATORY	7,823	16,928	51,121	61,743	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	621	1,052	3,315	8,906	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,528	4,763	15,016	21,595	1	65.00
66.00	06600	PHYSICAL THERAPY	18	828	2,610	10,415	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18	629	1,983	8,710	0	67.00
68.00	06800	SPEECH PATHOLOGY	30	275	866	3,350	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39	2,698	8,504	5,988	15	69.00
69.01	06901	CARDIAC REHAB	6	95	299	2,827	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,750	8,668	7,823	30	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,100	5,312	16,745	67,880	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,531	2,853	8,994	57,233	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,238	16,197	51,061	85,588	0	73.00
74.00	07400	RENAL DIALYSIS	73	910	2,870	11,134	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	191	2,708	8,537	31,810	2	90.00
91.00	09100	EMERGENCY	5,159	7,696	24,260	65,833	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	272	371	1,171	15,101	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,511	133,465	418,492	1,283,150	3,933	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	124	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description			PURCHASING RECEIVING AND STORES	ADM ITTING	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATIO N	
			5.02	5.03	5.04	5.05	5.06	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	788	0	0	200,438	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	3,472	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	1	0	0	1,878	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	100,300	133,465	418,492	1,489,062	3,933	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 6/25/2020 8:03 am			
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT	4,192,741					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,799	330,028				8.00
9.00	00900	HOUSEKEEPING	91,221	0	410,053			9.00
10.00	01000	DIETARY	83,321	0	8,493	372,877		10.00
11.00	01100	CAFETERIA	58,252	0	5,938	0	256,427	11.00
13.00	01300	NURSING ADMINISTRATION	28,071	0	2,861	0	6,598	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	158,451	562	16,152	0	3,321	14.00
15.00	01500	PHARMACY	83,803	0	8,542	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,985	0	5,095	0	8,262	16.00
17.00	01700	SOCIAL SERVICE	7,201	0	734	0	1,378	17.00
17.01	01701	STAFF EDUCATION	49,278	0	5,023	0	0	17.01
17.02	01702	MEDICAL EDUCATION	1,653	0	169	0	0	17.02
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	19,747	0	2,013	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	14,871	0	1,516	0	2,915	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,384,643	140,048	141,140	294,504	88,405	30.00
31.00	03100	INTENSIVE CARE UNIT	87,813	22,951	8,951	14,360	14,146	31.00
31.01	03101	NEONATAL ICU	9,982	0	1,018	0	3,527	31.01
40.00	04000	SUBPROVIDER - IPF	17,559	0	1,790	10,013	3,094	40.00
41.00	04100	SUBPROVIDER - IRF	138,116	22,640	14,079	32,713	7,721	41.00
43.00	04300	NURSERY	107,971	4,745	11,006	0	2,837	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	263,681	35,277	26,878	0	12,039	50.00
50.01	05001	ENDOSCOPY	0	6,267	0	0	3,119	50.01
51.00	05100	RECOVERY ROOM	64,303	2,188	6,555	0	2,300	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,958	4,794	3,156	9,478	7,746	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	234,558	8,828	23,909	0	8,051	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	22,342	2,453	2,277	0	3,192	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	59,613	1,901	6,077	0	1,239	55.00
55.01	05501	INFUSION CENTER	1,591	0	162	0	24	55.01
56.00	05600	RADIOISOTOPE	39,976	2,177	4,075	0	1,192	56.00
57.00	05700	CT SCAN	37,854	2,995	3,859	0	3,325	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,589	1,293	1,895	0	1,230	58.00
59.00	05900	CARDIAC CATHETERIZATION	35,511	8,308	3,620	0	4,913	59.00
60.00	06000	LABORATORY	103,966	0	10,598	0	11,274	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,702	0	173	0	5,972	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,331	0	3,500	0	7,316	65.00
66.00	06600	PHYSICAL THERAPY	54,242	105	5,529	0	3,359	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,616	567	4,752	0	2,927	67.00
68.00	06800	SPEECH PATHOLOGY	7,940	0	809	0	1,017	68.00
69.00	06900	ELECTROCARDIOLOGY	0	493	0	0	2,249	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	1,209	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	956	0	0	2,347	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,347	0	749	0	1,010	73.00
74.00	07400	RENAL DIALYSIS	19,376	4,320	1,975	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	336,773	12,503	34,329	0	6,467	90.00
91.00	09100	EMERGENCY	119,637	43,657	12,195	11,809	20,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,011,643	330,028	391,592	372,877	256,427	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,962	0	812	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	118,081	0	12,037	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
192.01	19201	OTHER NON-REIMBURSABLE	15,282	0	1,558	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	39,773	0	4,054	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,192,741	330,028	410,053	372,877	256,427	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 6/25/2020 8:03 am			
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
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	148,551					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	677,725				14.00
15.00	01500	PHARMACY	0	0	380,639			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	234,911		16.00
17.00	01700	SOCIAL SERVICE	1,204	0	0	0	35,523	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	2,548	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	77,281	0	0	19,918	28,367	30.00
31.00	03100	INTENSIVE CARE UNIT	12,366	0	0	3,218	0	31.00
31.01	03101	NEONATAL ICU	3,084	0	0	914	0	31.01
40.00	04000	SUBPROVIDER - IPF	2,705	0	0	924	0	40.00
41.00	04100	SUBPROVIDER - IRF	6,750	0	0	1,338	5,684	41.00
43.00	04300	NURSERY	2,480	0	0	424	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,524	0	0	26,610	0	50.00
50.01	05001	ENDOSCOPY	2,726	0	0	3,510	0	50.01
51.00	05100	RECOVERY ROOM	2,010	0	0	1,874	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,772	0	0	818	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,642	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	3,437	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,877	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	43	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	2,904	0	56.00
57.00	05700	CT SCAN	0	0	0	23,410	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,692	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,844	0	59.00
60.00	06000	LABORATORY	0	0	30,650	28,472	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	1,863	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,438	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,467	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,114	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	486	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,779	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	168	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,871	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	365,737	0	9,409	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	311,988	0	5,054	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	343,788	28,693	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,613	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	4,797	0	90.00
91.00	09100	EMERGENCY	18,101	0	0	13,632	1,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	721	658	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	148,551	677,725	375,159	234,911	35,523	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

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 6/25/2020 8:03 am	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,480	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	148,551	677,725	380,639	234,911	35,523	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description	STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00	
			SERVICES-SALARY & FRINGES 21.00	SERVICES-OTHER PRGM COSTS 22.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00550 DATA PROCESSING						5.01
5.02 00560 PURCHASING RECEIVING AND STORES						5.02
5.03 00570 ADMITTING						5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 00590 OTHER A&G						5.05
5.06 00592 PATIENT TRANSPORTATION						5.06
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE						17.00
17.01 01701 STAFF EDUCATION	206,829					17.01
17.02 01702 MEDICAL EDUCATION	0	7,168				17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,123			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		83,041		22.00
23.00 02300 PARAMED PROGRAM	272	0			72,031	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	94,238	0				30.00
31.00 03100 INTENSIVE CARE UNIT	17,785	0				31.00
31.01 03101 NEONATAL ICU	1,520	0				31.01
40.00 04000 SUBPROVIDER - IPF	1,637	0				40.00
41.00 04100 SUBPROVIDER - IRF	8,941	0				41.00
43.00 04300 NURSERY	4,645	0				43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	12,764	0				50.00
50.01 05001 ENDOSCOPY	3,991	0				50.01
51.00 05100 RECOVERY ROOM	1,581	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	9,117	0				52.00
53.00 05300 ANESTHESIOLOGY	0	0				53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,565	0				54.00
54.01 05401 RADIOLOGY - ULTRASOUND	848	0				54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	668	0				55.00
55.01 05501 INFUSION CENTER	0	0				55.01
56.00 05600 RADIOISOTOPE	15	0				56.00
57.00 05700 CT SCAN	1,715	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	104	0				58.00
59.00 05900 CARDIAC CATHETERIZATION	7,509	0				59.00
60.00 06000 LABORATORY	313	0				60.00
60.01 06001 BLOOD LABORATORY	0	0				60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	221	0				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65.00 06500 RESPIRATORY THERAPY	4,238	0				65.00
66.00 06600 PHYSICAL THERAPY	171	0				66.00
67.00 06700 OCCUPATIONAL THERAPY	177	0				67.00
68.00 06800 SPEECH PATHOLOGY	157	0				68.00
69.00 06900 ELECTROCARDIOLOGY	246	0				69.00
69.01 06901 CARDIAC REHAB	0	0				69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	263	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	33	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	664	0				90.00
91.00 09100 EMERGENCY	21,227	7,168				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	4,225	0				101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	202,850	7,168	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description	STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00	
			SERVICES-SALARY & FRINGES 21.00	SERVICES-OTHER PRGM COSTS 22.00		
191.00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	3,964	0				192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0				192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	15	0				192.02
193.00 19300 NONPAID WORKERS	0	0				193.00
200.00 Cross Foot Adjustments			1,123	83,041	72,031	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	206,829	7,168	1,123	83,041	72,031	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 6/25/2020 8:03 am
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 00100	CAP REL COSTS-BLDG & FIXT			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01 00550	DATA PROCESSING			5.01
5.02 00560	PURCHASING RECEIVING AND STORES			5.02
5.03 00570	ADMITTING			5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05 00590	OTHER A&G			5.05
5.06 00592	PATIENT TRANSPORTATION			5.06
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
13.00 01300	NURSING ADMINISTRATION			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY			14.00
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
17.00 01700	SOCIAL SERVICE			17.00
17.01 01701	STAFF EDUCATION			17.01
17.02 01702	MEDICAL EDUCATION			17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00 02300	PARAMED ED PROGRAM			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	6,836,028	0	6,836,028
31.00 03100	INTENSIVE CARE UNIT	512,154	0	512,154
31.01 03101	NEONATAL ICU	64,448	0	64,448
40.00 04000	SUBPROVIDER - IPF	103,008	0	103,008
41.00 04100	SUBPROVIDER - IRF	688,800	0	688,800
43.00 04300	NURSERY	479,415	0	479,415
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	1,316,948	0	1,316,948
50.01 05001	ENDOSCOPY	45,796	0	45,796
51.00 05100	RECOVERY ROOM	292,302	0	292,302
52.00 05200	DELIVERY ROOM & LABOR ROOM	192,368	0	192,368
53.00 05300	ANESTHESIOLOGY	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,057,125	0	1,057,125
54.01 05401	RADIOLOGY - ULTRASOUND	123,931	0	123,931
55.00 05500	RADIOLOGY-THERAPEUTIC	278,933	0	278,933
55.01 05501	INFUSION CENTER	6,922	0	6,922
56.00 05600	RADIOISOTOPE	195,610	0	195,610
57.00 05700	CT SCAN	263,761	0	263,761
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	107,222	0	107,222
59.00 05900	CARDIAC CATHETERIZATION	237,897	0	237,897
60.00 06000	LABORATORY	645,009	0	645,009
60.01 06001	BLOOD LABORATORY	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY			
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	29,692	0	29,692
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0
65.00 06500	RESPIRATORY THERAPY	207,786	0	207,786
66.00 06600	PHYSICAL THERAPY	246,549	0	246,549
67.00 06700	OCCUPATIONAL THERAPY	211,706	0	211,706
68.00 06800	SPEECH PATHOLOGY	39,637	0	39,637
69.00 06900	ELECTROCARDIOLOGY	25,404	0	25,404
69.01 06901	CARDIAC REHAB	4,829	0	4,829
70.00 07000	ELECTROENCEPHALOGRAPHY	28,189	0	28,189
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	496,183	0	496,183
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	412,653	0	412,653
73.00 07300	DRUGS CHARGED TO PATIENTS	558,553	0	558,553
74.00 07400	RENAL DIALYSIS	101,944	0	101,944
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	1,477,327	0	1,477,327
91.00 09100	EMERGENCY	744,981	0	744,981
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
OTHER REIMBURSABLE COST CENTERS				
101.00 10100	HOME HEALTH AGENCY	23,677	0	23,677
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	18,056,787	0	18,056,787

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,418	0	33,418	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	716,458	0	716,458	192.00
192.01	19201	OTHER NON-REIMBURSABLE	67,378	0	67,378	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	168,303	0	168,303	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	156,195	0	156,195	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,198,539	0	19,198,539	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHI NE TIME)	PURCHASI NG RECEI VI NG AND STORES (PURCHASE REQUI SI TI ONS)	ADMI TTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,410,133				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,906	147,265,628			4.00
5.01 00550	DATA PROCESSING	9,190	3,998,413	100		5.01
5.02 00560	PURCHASING RECEIVING AND STORES	7,332	873,756	0	37,978,697	5.02
5.03 00570	ADMITTING	9,717	1,930,169	0	44,175	1,266,100,952
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	30,646	2,224,383	0	15,621	0
5.05 00590	OTHER A&G	99,579	10,806,604	100	46,369	0
5.06 00592	PATIENT TRANSPORTATION	0	550,369	0	4,182	0
7.00 00700	OPERATION OF PLANT	299,329	3,821,698	0	490,578	0
8.00 00800	LAUNDRY & LINEN SERVICE	17,825	0	0	358	0
9.00 00900	HOUSEKEEPING	20,635	4,461,333	0	382,179	0
10.00 01000	DIETARY	18,848	2,051,059	0	633,558	0
11.00 01100	CAFETERIA	13,177	1,542,748	0	1,044	0
13.00 01300	NURSING ADMINISTRATION	6,350	3,222,427	0	24,588	0
14.00 01400	CENTRAL SERVICES & SUPPLY	35,843	619,842	0	0	0
15.00 01500	PHARMACY	18,957	0	0	133,035	0
16.00 01600	MEDICAL RECORDS & LIBRARY	11,307	1,966,875	0	6,425	0
17.00 01700	SOCIAL SERVICE	1,629	407,414	0	0	0
17.01 01701	STAFF EDUCATION	11,147	0	0	0	0
17.02 01702	MEDICAL EDUCATION	374	0	0	1,113	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,467	0	0	0	0
23.00 02300	PARAMED ED PROGRAM	3,364	737,359	0	6,832	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	313,217	31,670,464	0	2,205,612	107,083,680
31.00 03100	INTENSIVE CARE UNIT	19,864	5,959,503	0	818,156	17,300,097
31.01 03101	NEONATAL ICU	2,258	1,560,179	0	12,033	4,913,332
40.00 04000	SUBPROVIDER - I/PF	3,972	1,208,668	0	943	4,966,991
41.00 04100	SUBPROVIDER - I/RF	31,243	2,659,975	0	96,521	7,194,491
43.00 04300	NURSERY	24,424	1,232,034	0	154,273	2,277,786
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	59,647	3,960,153	0	1,228,586	143,066,646
50.01 05001	ENDOSCOPY	0	1,152,017	0	670,968	18,868,420
51.00 05100	RECOVERY ROOM	14,546	1,039,418	0	36,912	10,077,869
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,003	2,903,655	0	120,375	4,396,544
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	53,059	2,376,258	0	152,802	41,086,561
54.01 05401	RADIOLOGY - ULTRASOUND	5,054	1,211,922	0	128,539	18,476,481
55.00 05500	RADIOLOGY-THERAPEUTIC	13,485	467,047	0	29,917	20,844,494
55.01 05501	INFUSION CENTER	360	8,099	0	764	232,368
56.00 05600	RADIOISOTOPE	9,043	513,737	0	1,074,023	15,612,820
57.00 05700	CT SCAN	8,563	1,057,425	0	294,829	125,859,121
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,205	406,713	0	82,657	30,600,361
59.00 05900	CARDIAC CATHETERIZATION	8,033	2,102,949	0	517,063	69,051,548
60.00 06000	LABORATORY	23,518	3,534,845	0	2,961,969	156,224,313
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1,144,908	0	234,956	10,016,410
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	7,766	2,431,703	0	578,662	45,364,538
66.00 06600	PHYSICAL THERAPY	12,270	1,379,574	0	6,903	7,884,598
67.00 06700	OCCUPATIONAL THERAPY	10,545	1,183,313	0	7,004	5,990,640
68.00 06800	SPEECH PATHOLOGY	1,796	466,863	0	11,213	2,614,967
69.00 06900	ELECTROCARDIOLOGY	0	719,542	0	14,649	25,691,629
69.01 06901	CARDIAC REHAB	0	411,500	0	2,414	903,058
70.00 07000	ELECTROENCEPHALOGRAPHY	0	880,816	0	0	26,186,485
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,776,424	50,588,056
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,045,657	27,173,221
73.00 07300	DRUGS CHARGED TO PATIENTS	1,662	405,415	0	468,591	154,261,776
74.00 07400	RENAL DIALYSIS	4,383	164	0	27,732	8,671,001
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	76,181	2,498,814	0	72,316	25,791,599
91.00 09100	EMERGENCY	27,063	7,223,109	0	1,953,348	73,292,539
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	2,121,771	0	102,874	3,536,512

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUIREMENTS)	ADMITTING (GROSS CHARGES)		
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00	5.01	5.02	5.03			
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		1,369,167	125,107,002	100	37,679,742	1,266,100,952	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,801	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,711	21,991,859	0	298,498	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	3,457	0	0	32	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	8,997	166,767	0	425	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	19,198,539	31,675,809	11,588,567	4,106,092	2,926,934	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.614701	0.215093	115,885.67000	0.108116	0.002312	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		80,408	127,302	100,300	133,465	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000546	1,273.020000	0.002641	0.000105	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B-1 Date/Time Prepared: 6/25/2020 8:03 am		
Cost Center Description	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation n	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION N (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
	5.04	5A.05	5.05	5.06	7.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00570	ADMITTING				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,266,100,952			5.04
5.05	00590	OTHER A&G	0	-35,779,783		5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	718,611	44,058
7.00	00700	OPERATION OF PLANT	0	0	22,639,954	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,696,000	0
9.00	00900	HOUSEKEEPING	0	0	6,836,243	0
10.00	01000	DIETARY	0	0	4,298,560	0
11.00	01100	CAFETERIA	0	0	2,379,541	0
13.00	01300	NURSING ADMINISTRATION	0	0	4,513,549	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,164,826	1
15.00	01500	PHARMACY	0	0	5,923,594	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,281,852	0
17.00	01700	SOCIAL SERVICE	0	0	517,224	0
17.01	01701	STAFF EDUCATION	0	0	151,763	0
17.02	01702	MEDICAL EDUCATION	0	0	49,829	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	222,850	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	91,985	0
23.00	02300	PARAMED ED PROGRAM	0	0	731,804	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	107,083,680	0	46,023,031	17,253
31.00	03100	INTENSIVE CARE UNIT	17,300,097	0	9,355,683	233
31.01	03101	NEONATAL ICU	4,913,332	0	2,110,586	1
40.00	04000	SUBPROVIDER - IPF	4,966,991	0	1,663,086	0
41.00	04100	SUBPROVIDER - IRF	7,194,491	0	4,083,370	393
43.00	04300	NURSERY	2,277,786	0	2,125,303	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	143,066,646	0	9,786,667	3
50.01	05001	ENDOSCOPY	18,868,420	0	3,069,724	985
51.00	05100	RECOVERY ROOM	10,077,869	0	1,665,518	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,396,544	0	4,034,131	414
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,086,561	0	5,592,989	4,390
54.01	05401	RADIOLOGY - ULTRASOUND	18,476,481	0	2,204,135	4,578
55.00	05500	RADIOLOGY-THERAPEUTIC	20,844,494	0	2,484,199	259
55.01	05501	INFUSION CENTER	232,368	0	18,740	0
56.00	05600	RADIOISOTOPE	15,612,820	0	2,384,109	2,407
57.00	05700	CT SCAN	125,859,121	0	3,385,977	8,158
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	30,600,361	0	1,417,731	2,720
59.00	05900	CARDIAC CATHETERIZATION	69,051,548	0	4,580,413	1,390
60.00	06000	LABORATORY	156,224,313	0	12,252,939	0
60.01	06001	BLOOD LABORATORY	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,016,410	0	1,767,431	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	45,364,538	0	4,285,537	12
66.00	06600	PHYSICAL THERAPY	7,884,598	0	2,066,815	0
67.00	06700	OCCUPATIONAL THERAPY	5,990,640	0	1,728,581	0
68.00	06800	SPEECH PATHOLOGY	2,614,967	0	664,775	0
69.00	06900	ELECTROCARDIOLOGY	25,691,629	0	1,188,253	168
69.01	06901	CARDIAC REHAB	903,058	0	561,081	0
70.00	07000	ELECTROENCEPHALOGRAPHY	26,186,485	0	1,552,470	341
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,588,056	0	13,470,980	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,173,221	0	11,358,078	0
73.00	07300	DRUGS CHARGED TO PATIENTS	154,261,776	0	16,985,109	0
74.00	07400	RENAL DIALYSIS	8,671,001	0	2,209,561	3
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,791,599	0	6,312,741	17
91.00	09100	EMERGENCY	73,292,539	0	13,064,606	332
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,536,512	0	2,996,860	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,266,100,952	-35,779,783	254,669,394	44,058
					907,468	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description		CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)		
		5.04	5A.05	5.05	5.06	7.00		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24,531	0	1,801	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	39,777,381	0	26,711	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	689,024	0	3,457	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	372,743	0	8,997	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,618,197		35,779,783	805,613	25,380,951	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006017		0.121069	18.285283	26.760904	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	418,492		1,489,062	3,933	4,192,741	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000331		0.005039	0.089269	4.420699	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet B-1	
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATIVE (DIRECT NURS. HRS.)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
5.06	00592						5.06
7.00	00700						7.00
8.00	00800	1,830,620					8.00
9.00	00900	0	909,974				9.00
10.00	01000	0	18,848	355,755			10.00
11.00	01100	0	13,177	0	2,559,548		11.00
13.00	01300	0	6,350	0	65,855	1,696,190	13.00
14.00	01400	3,118	35,843	0	33,147	0	14.00
15.00	01500	0	18,957	0	0	0	15.00
16.00	01600	0	11,307	0	82,469	0	16.00
17.00	01700	0	1,629	0	13,752	13,752	17.00
17.01	01701	0	11,147	0	0	0	17.01
17.02	01702	0	374	0	0	0	17.02
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	4,467	0	0	0	22.00
23.00	02300	0	3,364	0	29,094	29,094	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	776,827	313,217	280,980	882,418	882,418	30.00
31.00	03100	127,304	19,864	13,701	141,197	141,197	31.00
31.01	03101	0	2,258	0	35,209	35,209	31.01
40.00	04000	0	3,972	9,553	30,886	30,886	40.00
41.00	04100	125,582	31,243	31,211	77,070	77,070	41.00
43.00	04300	26,318	24,424	0	28,314	28,314	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	195,676	59,647	0	120,169	120,169	50.00
50.01	05001	34,762	0	0	31,128	31,128	50.01
51.00	05100	12,138	14,546	0	22,955	22,955	51.00
52.00	05200	26,589	7,003	9,043	77,319	77,319	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	48,970	53,059	0	80,365	0	54.00
54.01	05401	13,604	5,054	0	31,858	0	54.01
55.00	05500	10,542	13,485	0	12,368	0	55.00
55.01	05501	0	360	0	239	0	55.01
56.00	05600	12,075	9,043	0	11,898	0	56.00
57.00	05700	16,615	8,563	0	33,189	0	57.00
58.00	05800	7,172	4,205	0	12,281	0	58.00
59.00	05900	46,086	8,033	0	49,042	0	59.00
60.00	06000	0	23,518	0	112,537	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	385	0	59,613	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	7,766	0	73,026	0	65.00
66.00	06600	581	12,270	0	33,524	0	66.00
67.00	06700	3,144	10,545	0	29,216	0	67.00
68.00	06800	0	1,796	0	10,147	0	68.00
69.00	06900	2,734	0	0	22,452	0	69.00
69.01	06901	0	0	0	12,069	0	69.01
70.00	07000	5,302	0	0	23,431	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	1,662	0	10,081	0	73.00
74.00	07400	23,965	4,383	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	69,354	76,181	0	64,551	0	90.00
91.00	09100	242,162	27,063	11,267	206,679	206,679	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,830,620	869,008	355,755	2,559,548	1,696,190	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		8.00	9.00	10.00	11.00	13.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,801	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,711	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	3,457	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	8,997	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,378,346	8,216,111	5,493,550	3,139,232	5,368,036
203.00		Unit cost multiplier (Wkst. B, Part I)	1.299202	9.028951	15.441947	1.226479	3.164761
204.00		Cost to be allocated (per Wkst. B, Part II)	330,028	410,053	372,877	256,427	148,551
205.00		Unit cost multiplier (Wkst. B, Part II)	0.180282	0.450621	1.048129	0.100184	0.087579
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet B-1	
Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	Date/Time Prepared: 6/25/2020 8:03 am
		14.00	15.00	16.00	17.00	17.01	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
5.06	00592						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	21,822,081					14.00
15.00	01500		16,537,962				15.00
16.00	01600			1,266,100,952			16.00
17.00	01700				700		17.00
17.01	01701					107,802	17.01
17.02	01702						17.02
21.00	02100						21.00
22.00	02200						22.00
23.00	02300					142	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000			107,083,680	559	49,119	30.00
31.00	03100			17,300,097		9,270	31.00
31.01	03101			4,913,332		792	31.01
40.00	04000			4,966,991		853	40.00
41.00	04100			7,194,491	112	4,660	41.00
43.00	04300			2,277,786		2,421	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000			143,066,646		6,653	50.00
50.01	05001			18,868,420		2,080	50.01
51.00	05100			10,077,869		824	51.00
52.00	05200			4,396,544		4,752	52.00
53.00	05300						53.00
54.00	05400			41,086,561		1,858	54.00
54.01	05401			18,476,481		442	54.01
55.00	05500			20,844,494		348	55.00
55.01	05501			232,368			55.01
56.00	05600			15,612,820		8	56.00
57.00	05700			125,859,121		894	57.00
58.00	05800			30,600,361		54	58.00
59.00	05900			69,051,548		3,914	59.00
60.00	06000		1,331,688	156,224,313		163	60.00
60.01	06001						60.01
61.00	06100						61.00
62.00	06200			10,016,410		115	62.00
63.00	06300						63.00
64.00	06400						64.00
65.00	06500			45,364,538		2,209	65.00
66.00	06600			7,884,598		89	66.00
67.00	06700			5,990,640		92	67.00
68.00	06800			2,614,967		82	68.00
69.00	06900			25,691,629		128	69.00
69.01	06901			903,058			69.01
70.00	07000			26,186,485		137	70.00
71.00	07100	11,776,424		50,588,056			71.00
72.00	07200	10,045,657		27,173,221			72.00
73.00	07300		14,936,845	154,261,776		17	73.00
74.00	07400			8,671,001			74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000			25,791,599		346	90.00
91.00	09100			73,292,539	29	11,064	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100		31,345	3,536,512		2,202	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		21,822,081	16,299,878	1,266,100,952	700	105,728	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
		14.00	15.00	16.00	17.00	17.01	
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	238,084	0	2,066	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	8	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,754,458	7,319,226	4,185,005	698,535	569,087
203.00		Unit cost multiplier (Wkst. B, Part I)	0.172049	0.442571	0.003305	997.907143	5.279002
204.00		Cost to be allocated (per Wkst. B, Part II)	677,725	380,639	234,911	35,523	206,829
205.00		Unit cost multiplier (Wkst. B, Part II)	0.031057	0.023016	0.000186	50.747143	1.918601
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PROGRAM (ASSIGNED TIME)						
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)							
		17.02	21.00				22.00	23.00		
GENERAL SERVICE COST CENTERS										
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00				
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00				
5.01 00550 DATA PROCESSING						5.01				
5.02 00560 PURCHASING RECEIVING AND STORES						5.02				
5.03 00570 ADMITTING						5.03				
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04				
5.05 00590 OTHER A&G						5.05				
5.06 00592 PATIENT TRANSPORTATION						5.06				
7.00 00700 OPERATION OF PLANT						7.00				
8.00 00800 LAUNDRY & LINEN SERVICE						8.00				
9.00 00900 HOUSEKEEPING						9.00				
10.00 01000 DIETARY						10.00				
11.00 01100 CAFETERIA						11.00				
13.00 01300 NURSING ADMINISTRATION						13.00				
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00				
15.00 01500 PHARMACY						15.00				
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00				
17.00 01700 SOCIAL SERVICE						17.00				
17.01 01701 STAFF EDUCATION						17.01				
17.02 01702 MEDICAL EDUCATION	100					17.02				
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	100				21.00				
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100			22.00				
23.00 02300 PARAMED PROGRAM	0			100		23.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00				
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00				
31.01 03101 NEONATAL ICU	0	0	0	0	0	31.01				
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00				
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00				
43.00 04300 NURSERY	0	0	0	0	0	43.00				
ANCILLARY SERVICE COST CENTERS										
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00				
50.01 05001 ENDOSCOPY	0	0	0	0	0	50.01				
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00				
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00				
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00				
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01				
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00				
55.01 05501 INFUSION CENTER	0	0	0	0	0	55.01				
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00				
57.00 05700 CT SCAN	0	0	0	0	0	57.00				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00				
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00				
60.00 06000 LABORATORY	0	0	0	0	0	60.00				
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01				
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00				
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00				
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00				
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00				
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00				
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00				
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00				
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00				
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00				
69.01 06901 CARDIAC REHAB	0	0	0	0	0	69.01				
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00				
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00				
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00				
OUTPATIENT SERVICE COST CENTERS										
90.00 09000 CLINIC	0	0	0	0	0	90.00				
91.00 09100 EMERGENCY	100	100	100	100	100	91.00				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00				
OTHER REIMBURSABLE COST CENTERS										
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00				
SPECIAL PURPOSE COST CENTERS										
118.00	SUBTOTALS (SUM OF LINES 1 through 117)					100	100	100	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PROGRAM (ASSIGNED TIME)			
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
		17.02	21.00				22.00
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
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	69,248	249,830	262,995	1,069,309	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	692.480000	2,498.300000	2,629.950000	10,693.090000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,168	1,123	83,041	72,031	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	71.680000	11.230000	830.410000	720.310000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

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

Worksheet C
Part I
Date/Time Prepared:
6/25/2020 8:03 am

		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		73,514,433	12,477	73,526,910	30.00
31.00	03100	INTENSIVE CARE UNIT		12,306,663	0	12,306,663	31.00
31.01	03101	NEONATAL ICU		2,621,975	0	2,621,975	31.01
40.00	04000	SUBPROVIDER - I/PF		2,310,655	0	2,310,655	40.00
41.00	04100	SUBPROVIDER - I/RF		6,846,801	0	6,846,801	41.00
43.00	04300	NURSERY		3,435,576	0	3,435,576	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		14,396,212	0	14,396,212	50.00
50.01	05001	ENDOSCOPY		3,714,577	0	3,714,577	50.01
51.00	05100	RECOVERY ROOM		2,541,988	0	2,541,988	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		5,334,075	0	5,334,075	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		8,557,160	0	8,557,160	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		2,855,724	0	2,855,724	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		3,371,913	0	3,371,913	55.00
55.01	05501	INFUSION CENTER		34,954	0	34,954	55.01
56.00	05600	RADIOISOTOPE		3,122,335	0	3,122,335	56.00
57.00	05700	CT SCAN		4,734,529	0	4,734,529	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		1,915,406	0	1,915,406	58.00
59.00	05900	CARDIAC CATHETERIZATION		5,816,777	0	5,816,777	59.00
60.00	06000	LABORATORY		15,823,209	0	15,823,209	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		2,102,016	0	2,102,016	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,333,702	0	5,333,702	65.00
66.00	06600	PHYSICAL THERAPY	0	2,824,583	0	2,824,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,375,466	0	2,375,466	67.00
68.00	06800	SPEECH PATHOLOGY	0	831,058	0	831,058	68.00
69.00	06900	ELECTROCARDIOLOGY		1,451,862	0	1,451,862	69.00
69.01	06901	CARDIAC REHAB		646,798	0	646,798	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		1,869,556	0	1,869,556	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		17,295,205	0	17,295,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		14,551,341	0	14,551,341	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		26,233,870	0	26,233,870	73.00
74.00	07400	RENAL DIALYSIS		2,693,785	0	2,693,785	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		10,060,179	0	10,060,179	90.00
91.00	09100	EMERGENCY		18,485,290	0	18,485,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		17,149,487	0	17,149,487	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		3,396,871		3,396,871	101.00
200.00		Subtotal (see instructions)	0	300,556,031	12,477	300,568,508	200.00
201.00		Less Observation Beds		17,149,487		17,149,487	201.00
202.00		Total (see instructions)	0	283,406,544	12,477	283,419,021	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet C Part I Date/Time Prepared: 6/25/2020 8:03 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	74,729,498		74,729,498				30.00
31.00	03100	INTENSIVE CARE UNIT	17,300,097		17,300,097				31.00
31.01	03101	NEONATAL ICU	4,913,332		4,913,332				31.01
40.00	04000	SUBPROVIDER - IPF	4,966,991		4,966,991				40.00
41.00	04100	SUBPROVIDER - IRF	7,194,491		7,194,491				41.00
43.00	04300	NURSERY	2,277,786		2,277,786				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	74,739,176	68,327,470	143,066,646	0.100626	0.000000		50.00
50.01	05001	ENDOSCOPY	3,998,872	14,869,548	18,868,420	0.196867	0.000000		50.01
51.00	05100	RECOVERY ROOM	4,161,120	5,916,749	10,077,869	0.252235	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,679,650	2,716,894	4,396,544	1.213243	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,128,744	30,957,817	41,086,561	0.208272	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	4,848,261	13,628,220	18,476,481	0.154560	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,204,692	19,639,802	20,844,494	0.161765	0.000000		55.00
55.01	05501	INFUSION CENTER	5,351	227,017	232,368	0.150425	0.000000		55.01
56.00	05600	RADIOISOTOPE	5,581,302	10,031,518	15,612,820	0.199985	0.000000		56.00
57.00	05700	CT SCAN	45,835,085	80,024,036	125,859,121	0.037618	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,987,185	17,613,176	30,600,361	0.062594	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	29,831,490	39,220,058	69,051,548	0.084238	0.000000		59.00
60.00	06000	LABORATORY	62,317,258	93,907,055	156,224,313	0.101285	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,807,918	2,208,492	10,016,410	0.209857	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	40,233,207	5,131,331	45,364,538	0.117574	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	7,217,489	667,109	7,884,598	0.358241	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,593,932	396,708	5,990,640	0.396530	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,363,744	251,223	2,614,967	0.317808	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	13,303,680	12,387,949	25,691,629	0.056511	0.000000		69.00
69.01	06901	CARDIAC REHAB	250,163	652,895	903,058	0.716231	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9,567,776	16,618,709	26,186,485	0.071394	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,819,479	27,768,577	50,588,056	0.341883	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,922,656	12,250,565	27,173,221	0.535503	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,304,196	54,957,580	154,261,776	0.170061	0.000000		73.00
74.00	07400	RENAL DIALYSIS	7,615,815	1,055,186	8,671,001	0.310666	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	515,789	25,275,810	25,791,599	0.390056	0.000000		90.00
91.00	09100	EMERGENCY	16,536,787	56,755,752	73,292,539	0.252212	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,279,333	25,074,849	32,354,182	0.530055	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	3,536,512	3,536,512				101.00
200.00		Subtotal (see instructions)	624,032,345	642,068,607	1,266,100,952				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	624,032,345	642,068,607	1,266,100,952				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/25/2020 8:03 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL ICU		31.01
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.100626	50.00
50.01	05001	ENDOSCOPY	0.196867	50.01
51.00	05100	RECOVERY ROOM	0.252235	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.213243	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208272	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.154560	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.161765	55.00
55.01	05501	INFUSION CENTER	0.150425	55.01
56.00	05600	RADIOISOTOPE	0.199985	56.00
57.00	05700	CT SCAN	0.037618	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062594	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084238	59.00
60.00	06000	LABORATORY	0.101285	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209857	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.117574	65.00
66.00	06600	PHYSICAL THERAPY	0.358241	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.396530	67.00
68.00	06800	SPEECH PATHOLOGY	0.317808	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056511	69.00
69.01	06901	CARDIAC REHAB	0.716231	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071394	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.535503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170061	73.00
74.00	07400	RENAL DIALYSIS	0.310666	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.390056	90.00
91.00	09100	EMERGENCY	0.252212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530055	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-0002

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

Worksheet C
Part I
Date/Time Prepared:
6/25/2020 8:03 am

		Title XIX		Hospital		Cost	
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		73,514,433	12,477	73,526,910	30.00
31.00	03100	INTENSIVE CARE UNIT		12,306,663	0	12,306,663	31.00
31.01	03101	NEONATAL ICU		2,621,975	0	2,621,975	31.01
40.00	04000	SUBPROVIDER - I/PF		2,310,655	0	2,310,655	40.00
41.00	04100	SUBPROVIDER - I/RF		6,846,801	0	6,846,801	41.00
43.00	04300	NURSERY		3,435,576	0	3,435,576	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		14,396,212	0	14,396,212	50.00
50.01	05001	ENDOSCOPY		3,714,577	0	3,714,577	50.01
51.00	05100	RECOVERY ROOM		2,541,988	0	2,541,988	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		5,334,075	0	5,334,075	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		8,557,160	0	8,557,160	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		2,855,724	0	2,855,724	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		3,371,913	0	3,371,913	55.00
55.01	05501	INFUSION CENTER		34,954	0	34,954	55.01
56.00	05600	RADIOISOTOPE		3,122,335	0	3,122,335	56.00
57.00	05700	CT SCAN		4,734,529	0	4,734,529	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		1,915,406	0	1,915,406	58.00
59.00	05900	CARDIAC CATHETERIZATION		5,816,777	0	5,816,777	59.00
60.00	06000	LABORATORY		15,823,209	0	15,823,209	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		2,102,016	0	2,102,016	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,333,702	0	5,333,702	65.00
66.00	06600	PHYSICAL THERAPY	0	2,824,583	0	2,824,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,375,466	0	2,375,466	67.00
68.00	06800	SPEECH PATHOLOGY	0	831,058	0	831,058	68.00
69.00	06900	ELECTROCARDIOLOGY		1,451,862	0	1,451,862	69.00
69.01	06901	CARDIAC REHAB		646,798	0	646,798	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		1,869,556	0	1,869,556	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		17,295,205	0	17,295,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		14,551,341	0	14,551,341	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		26,233,870	0	26,233,870	73.00
74.00	07400	RENAL DIALYSIS		2,693,785	0	2,693,785	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		10,060,179	0	10,060,179	90.00
91.00	09100	EMERGENCY		18,485,290	0	18,485,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		17,149,487	0	17,149,487	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		3,396,871		3,396,871	101.00
200.00		Subtotal (see instructions)	0	300,556,031	12,477	300,568,508	200.00
201.00		Less Observation Beds		17,149,487		17,149,487	201.00
202.00		Total (see instructions)	0	283,406,544	12,477	283,419,021	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet C Part I Date/Time Prepared: 6/25/2020 8:03 am		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	74,729,498		74,729,498				30.00
31.00	03100	INTENSIVE CARE UNIT	17,300,097		17,300,097				31.00
31.01	03101	NEONATAL ICU	4,913,332		4,913,332				31.01
40.00	04000	SUBPROVIDER - IPF	4,966,991		4,966,991				40.00
41.00	04100	SUBPROVIDER - IRF	7,194,491		7,194,491				41.00
43.00	04300	NURSERY	2,277,786		2,277,786				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	74,739,176	68,327,470	143,066,646	0.100626	0.000000		50.00
50.01	05001	ENDOSCOPY	3,998,872	14,869,548	18,868,420	0.196867	0.000000		50.01
51.00	05100	RECOVERY ROOM	4,161,120	5,916,749	10,077,869	0.252235	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,679,650	2,716,894	4,396,544	1.213243	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,128,744	30,957,817	41,086,561	0.208272	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	4,848,261	13,628,220	18,476,481	0.154560	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,204,692	19,639,802	20,844,494	0.161765	0.000000		55.00
55.01	05501	INFUSION CENTER	5,351	227,017	232,368	0.150425	0.000000		55.01
56.00	05600	RADIOISOTOPE	5,581,302	10,031,518	15,612,820	0.199985	0.000000		56.00
57.00	05700	CT SCAN	45,835,085	80,024,036	125,859,121	0.037618	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,987,185	17,613,176	30,600,361	0.062594	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	29,831,490	39,220,058	69,051,548	0.084238	0.000000		59.00
60.00	06000	LABORATORY	62,317,258	93,907,055	156,224,313	0.101285	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,807,918	2,208,492	10,016,410	0.209857	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	40,233,207	5,131,331	45,364,538	0.117574	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	7,217,489	667,109	7,884,598	0.358241	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,593,932	396,708	5,990,640	0.396530	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,363,744	251,223	2,614,967	0.317808	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	13,303,680	12,387,949	25,691,629	0.056511	0.000000		69.00
69.01	06901	CARDIAC REHAB	250,163	652,895	903,058	0.716231	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9,567,776	16,618,709	26,186,485	0.071394	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,819,479	27,768,577	50,588,056	0.341883	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,922,656	12,250,565	27,173,221	0.535503	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,304,196	54,957,580	154,261,776	0.170061	0.000000		73.00
74.00	07400	RENAL DIALYSIS	7,615,815	1,055,186	8,671,001	0.310666	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	515,789	25,275,810	25,791,599	0.390056	0.000000		90.00
91.00	09100	EMERGENCY	16,536,787	56,755,752	73,292,539	0.252212	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,279,333	25,074,849	32,354,182	0.530055	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	3,536,512	3,536,512				101.00
200.00		Subtotal (see instructions)	624,032,345	642,068,607	1,266,100,952				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	624,032,345	642,068,607	1,266,100,952				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/25/2020 8:03 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	03101 NEONATAL ICU			31.01
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	05001 ENDOSCOPY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501 INFUSION CENTER	0.000000		55.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part I Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII		Hospital
				PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,836,028	0	6,836,028	84,762	30.00
31.00	INTENSIVE CARE UNIT	512,154		512,154	7,574	31.00
31.01	NEONATAL ICU	64,448		64,448	2,213	31.01
40.00	SUBPROVIDER - IPF	103,008	0	103,008	3,016	40.00
41.00	SUBPROVIDER - IRF	688,800	0	688,800	7,786	41.00
43.00	NURSERY	479,415		479,415	2,632	43.00
200.00	Total (lines 30 through 199)	8,683,853		8,683,853	107,983	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	22,149	1,786,317
31.00	INTENSIVE CARE UNIT	4,320	292,118
31.01	NEONATAL ICU	0	0
40.00	SUBPROVIDER - IPF	1,363	46,546
41.00	SUBPROVIDER - IRF	4,740	419,348
43.00	NURSERY	0	0
200.00	Total (lines 30 through 199)	32,572	2,544,329

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 6/25/2020 8:03 am
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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	1,316,948	143,066,646	0.009205	22,382,919	206,035	50.00
50.01	05001 ENDOSCOPY	45,796	18,868,420	0.002427	1,546,537	3,753	50.01
51.00	05100 RECOVERY ROOM	292,302	10,077,869	0.029004	1,346,196	39,045	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	192,368	4,396,544	0.043754	28,747	1,258	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,057,125	41,086,561	0.025729	4,304,967	110,762	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	123,931	18,476,481	0.006708	1,634,949	10,967	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	278,933	20,844,494	0.013382	409,243	5,476	55.00
55.01	05501 INFUSION CENTER	6,922	232,368	0.029789	0	0	55.01
56.00	05600 RADIOISOTOPE	195,610	15,612,820	0.012529	2,230,007	27,940	56.00
57.00	05700 CT SCAN	263,761	125,859,121	0.002096	17,838,425	37,389	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	107,222	30,600,361	0.003504	4,845,029	16,977	58.00
59.00	05900 CARDIAC CATHETERIZATION	237,897	69,051,548	0.003445	10,210,786	35,176	59.00
60.00	06000 LABORATORY	645,009	156,224,313	0.004129	21,630,168	89,311	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	29,692	10,016,410	0.002964	3,597,929	10,664	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	207,786	45,364,538	0.004580	14,113,407	64,639	65.00
66.00	06600 PHYSICAL THERAPY	246,549	7,884,598	0.031270	1,708,279	53,418	66.00
67.00	06700 OCCUPATIONAL THERAPY	211,706	5,990,640	0.035339	1,094,240	38,669	67.00
68.00	06800 SPEECH PATHOLOGY	39,637	2,614,967	0.015158	885,957	13,429	68.00
69.00	06900 ELECTROCARDIOLOGY	25,404	25,691,629	0.000989	5,782,054	5,718	69.00
69.01	06901 CARDIAC REHAB	4,829	903,058	0.005347	283	2	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	28,189	26,186,485	0.001076	2,950,616	3,175	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	496,183	50,588,056	0.009808	8,419,923	82,583	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	412,653	27,173,221	0.015186	5,433,633	82,515	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	558,553	154,261,776	0.003621	33,883,399	122,692	73.00
74.00	07400 RENAL DIALYSIS	101,944	8,671,001	0.011757	3,498,938	41,137	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,477,327	25,791,599	0.057279	137,234	7,861	90.00
91.00	09100 EMERGENCY	744,981	73,292,539	0.010164	6,407,953	65,130	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,594,439	32,354,182	0.049281	3,452,088	170,122	92.00
200.00	Total (lines 50 through 199)	10,943,696	1,151,182,245		179,773,906	1,345,843	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	03101	NEONATAL ICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
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	84,762	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	7,574	0.00	31.00
31.01	03101	NEONATAL ICU	0	0	2,213	0.00	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	3,016	0.00	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,786	0.00	41.00
43.00	04300	NURSERY	0	0	2,632	0.00	43.00
200.00		Total (lines 30 through 199)	0	0	107,983	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
31.01	03101	NEONATAL ICU	0				31.01
40.00	04000	SUBPROVIDER - IPF	0				40.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
43.00	04300	NURSERY	0				43.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description	Title XVIII						Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health				
	1.00	2A	2.00	3A	3.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
50.01	05001	ENDOSCOPY	0	0	0	0	0	50.01	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
55.01	05501	INFUSION CENTER	0	0	0	0	0	55.01	
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	1,069,309	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)	0	0	0	0	1,069,309	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
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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 XVIII		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	143,066,646	0.000000	50.00	
50.01 05001 ENDOSCOPY	0	0	0	18,868,420	0.000000	50.01	
51.00 05100 RECOVERY ROOM	0	0	0	10,077,869	0.000000	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,396,544	0.000000	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,086,561	0.000000	54.00	
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	0	18,476,481	0.000000	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	20,844,494	0.000000	55.00	
55.01 05501 INFUSION CENTER	0	0	0	232,368	0.000000	55.01	
56.00 05600 RADIO SOTOPE	0	0	0	15,612,820	0.000000	56.00	
57.00 05700 CT SCAN	0	0	0	125,859,121	0.000000	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	30,600,361	0.000000	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	69,051,548	0.000000	59.00	
60.00 06000 LABORATORY	0	0	0	156,224,313	0.000000	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,016,410	0.000000	62.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	45,364,538	0.000000	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	7,884,598	0.000000	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	5,990,640	0.000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,614,967	0.000000	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	25,691,629	0.000000	69.00	
69.01 06901 CARDIAC REHAB	0	0	0	903,058	0.000000	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	26,186,485	0.000000	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	50,588,056	0.000000	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,173,221	0.000000	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	154,261,776	0.000000	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	8,671,001	0.000000	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	25,791,599	0.000000	90.00	
91.00 09100 EMERGENCY	0	1,069,309	1,069,309	73,292,539	0.014590	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	32,354,182	0.000000	92.00	
200.00 Total (lines 50 through 199)	0	1,069,309	1,069,309	1,151,182,245		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	22,382,919	0	17,967,859	0	50.00
50.01	05001 ENDOSCOPY	0.000000	1,546,537	0	3,659,444	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	1,346,196	0	1,776,009	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	28,747	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	4,304,967	0	5,431,282	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000	1,634,949	0	1,709,883	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	409,243	0	6,807,240	0	55.00
55.01	05501 INFUSION CENTER	0.000000	0	0	2	0	55.01
56.00	05600 RADIOISOTOPE	0.000000	2,230,007	0	2,709,860	0	56.00
57.00	05700 CT SCAN	0.000000	17,838,425	0	16,928,260	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	4,845,029	0	4,128,721	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	10,210,786	0	13,713,379	0	59.00
60.00	06000 LABORATORY	0.000000	21,630,168	0	7,710,770	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	3,597,929	0	328,331	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	14,113,407	0	874,952	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,708,279	0	3,518	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,094,240	0	6,044	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	885,957	0	36,842	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	5,782,054	0	3,148,682	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	283	0	176,361	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	2,950,616	0	4,347,208	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	8,419,923	0	6,878,081	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,433,633	0	3,773,954	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	33,883,399	0	15,821,998	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	3,498,938	0	486,001	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	137,234	0	5,206,788	0	90.00
91.00	09100 EMERGENCY	0.014590	6,407,953	93,492	6,968,869	101,676	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,452,088	0	3,726,428	0	92.00
200.00	Total (lines 50 through 199)		179,773,906	93,492	134,326,766	101,676	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.100626	17,967,859	0	0	1,808,034	50.00
50.01	05001	ENDOSCOPY	0.196867	3,659,444	0	0	720,424	50.01
51.00	05100	RECOVERY ROOM	0.252235	1,776,009	0	0	447,972	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.213243	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208272	5,431,282	0	0	1,131,184	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.154560	1,709,883	0	0	264,280	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.161765	6,807,240	0	0	1,101,173	55.00
55.01	05501	INFUSION CENTER	0.150425	2	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.199985	2,709,860	0	0	541,931	56.00
57.00	05700	CT SCAN	0.037618	16,928,260	0	0	636,807	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062594	4,128,721	0	0	258,433	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084238	13,713,379	0	0	1,155,188	59.00
60.00	06000	LABORATORY	0.101285	7,710,770	0	0	780,985	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209857	328,331	0	0	68,903	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.117574	874,952	0	0	102,872	65.00
66.00	06600	PHYSICAL THERAPY	0.358241	3,518	0	0	1,260	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.396530	6,044	0	0	2,397	67.00
68.00	06800	SPEECH PATHOLOGY	0.317808	36,842	0	0	11,709	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056511	3,148,682	0	0	177,935	69.00
69.01	06901	CARDIAC REHAB	0.716231	176,361	0	0	126,315	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071394	4,347,208	0	0	310,365	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341883	6,878,081	0	0	2,351,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.535503	3,773,954	0	0	2,020,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170061	15,821,998	0	46,691	2,690,705	73.00
74.00	07400	RENAL DIALYSIS	0.310666	486,001	0	0	150,984	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.390056	5,206,788	0	0	2,030,939	90.00
91.00	09100	EMERGENCY	0.252212	6,968,869	0	124	1,757,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530055	3,726,428	0	0	1,975,212	92.00
200.00		Subtotal (see instructions)		134,326,766	0	46,815	22,626,102	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		134,326,766	0	46,815	22,626,102	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0	0	50.00
50.01 05001	ENDOSCOPY	0	0	50.01
51.00 05100	RECOVERY ROOM	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401	RADIOLOGY - ULTRASOUND	0	0	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01 05501	INFUSION CENTER	0	0	55.01
56.00 05600	RADIOISOTOPE	0	0	56.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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
69.01 06901	CARDIAC REHAB	0	0	69.01
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	7,940	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0	0	90.00
91.00 09100	EMERGENCY	0	31	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	7,971	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	7,971	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 6/25/2020 8:03 am	
Title XVIII				Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,316,948	143,066,646	0.009205	0	50.00
50.01	05001	ENDOSCOPY	45,796	18,868,420	0.002427	0	50.01
51.00	05100	RECOVERY ROOM	292,302	10,077,869	0.029004	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	192,368	4,396,544	0.043754	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,057,125	41,086,561	0.025729	19,661	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	123,931	18,476,481	0.006708	12,946	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	278,933	20,844,494	0.013382	0	55.00
55.01	05501	INFUSION CENTER	6,922	232,368	0.029789	0	55.01
56.00	05600	RADIO SOTOP	195,610	15,612,820	0.012529	2,083	56.00
57.00	05700	CT SCAN	263,761	125,859,121	0.002096	56,361	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,222	30,600,361	0.003504	21,601	58.00
59.00	05900	CARDIAC CATHETERIZATION	237,897	69,051,548	0.003445	12,023	59.00
60.00	06000	LABORATORY	645,009	156,224,313	0.004129	200,627	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	29,692	10,016,410	0.002964	16,696	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	207,786	45,364,538	0.004580	4,233	65.00
66.00	06600	PHYSICAL THERAPY	246,549	7,884,598	0.031270	2,902	66.00
67.00	06700	OCCUPATIONAL THERAPY	211,706	5,990,640	0.035339	1,448	67.00
68.00	06800	SPEECH PATHOLOGY	39,637	2,614,967	0.015158	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,404	25,691,629	0.000989	47,368	69.00
69.01	06901	CARDIAC REHAB	4,829	903,058	0.005347	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	28,189	26,186,485	0.001076	2,085	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	496,183	50,588,056	0.009808	9,395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	412,653	27,173,221	0.015186	1,986	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	558,553	154,261,776	0.003621	539,721	73.00
74.00	07400	RENAL DIALYSIS	101,944	8,671,001	0.011757	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,477,327	25,791,599	0.057279	0	90.00
91.00	09100	EMERGENCY	744,981	73,292,539	0.010164	35,996	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	32,354,182	0.000000	0	92.00
200.00		Total (lines 50 through 199)	9,349,257	1,151,182,245		987,132	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 INFUSION CENTER	0	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	1,069,309	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	1,069,309	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
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	Title XVIII	Subprovider - IPF	PPS
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	143,066,646	0.000000	50.00
50.01 05001 ENDOSCOPY	0	0	0	18,868,420	0.000000	50.01
51.00 05100 RECOVERY ROOM	0	0	0	10,077,869	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,396,544	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,086,561	0.000000	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	0	18,476,481	0.000000	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	20,844,494	0.000000	55.00
55.01 05501 INFUSION CENTER	0	0	0	232,368	0.000000	55.01
56.00 05600 RADIOISOTOPE	0	0	0	15,612,820	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	125,859,121	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	30,600,361	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	69,051,548	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	156,224,313	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,016,410	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	45,364,538	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	7,884,598	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	5,990,640	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,614,967	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	25,691,629	0.000000	69.00
69.01 06901 CARDIAC REHAB	0	0	0	903,058	0.000000	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	26,186,485	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	50,588,056	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,173,221	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	154,261,776	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	8,671,001	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	25,791,599	0.000000	90.00
91.00 09100 EMERGENCY	0	1,069,309	1,069,309	73,292,539	0.014590	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	32,354,182	0.000000	92.00
200.00 Total (lines 50 through 199)	0	1,069,309	1,069,309	1,151,182,245		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	0.000000	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	19,661	0	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0.000000	12,946	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	0.000000	0	0	0	0	55.01
56.00 05600 RADIOISOTOPE	0.000000	2,083	0	0	0	56.00
57.00 05700 CT SCAN	0.000000	56,361	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	21,601	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	12,023	0	0	0	59.00
60.00 06000 LABORATORY	0.000000	200,627	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	16,696	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.000000	4,233	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	2,902	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	1,448	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	47,368	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0.000000	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	2,085	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	9,395	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,986	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	539,721	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.014590	35,996	525	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		987,132	525	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 6/25/2020 8:03 am	
Title XVIII				Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,316,948	143,066,646	0.009205	196,667	1,810	50.00
50.01	05001 ENDOSCOPY	45,796	18,868,420	0.002427	11,706	28	50.01
51.00	05100 RECOVERY ROOM	292,302	10,077,869	0.029004	12,755	370	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	192,368	4,396,544	0.043754	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,057,125	41,086,561	0.025729	116,403	2,995	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	123,931	18,476,481	0.006708	24,516	164	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	278,933	20,844,494	0.013382	45,374	607	55.00
55.01	05501 INFUSION CENTER	6,922	232,368	0.029789	0	0	55.01
56.00	05600 RADIO SOTOPE	195,610	15,612,820	0.012529	25,712	322	56.00
57.00	05700 CT SCAN	263,761	125,859,121	0.002096	355,412	745	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	107,222	30,600,361	0.003504	126,935	445	58.00
59.00	05900 CARDIAC CATHETERIZATION	237,897	69,051,548	0.003445	68,140	235	59.00
60.00	06000 LABORATORY	645,009	156,224,313	0.004129	861,444	3,557	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	29,692	10,016,410	0.002964	37,639	112	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	207,786	45,364,538	0.004580	715,398	3,277	65.00
66.00	06600 PHYSICAL THERAPY	246,549	7,884,598	0.031270	2,080,470	65,056	66.00
67.00	06700 OCCUPATIONAL THERAPY	211,706	5,990,640	0.035339	1,875,519	66,279	67.00
68.00	06800 SPEECH PATHOLOGY	39,637	2,614,967	0.015158	261,668	3,966	68.00
69.00	06900 ELECTROCARDIOLOGY	25,404	25,691,629	0.000989	40,169	40	69.00
69.01	06901 CARDIAC REHAB	4,829	903,058	0.005347	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	28,189	26,186,485	0.001076	16,258	17	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	496,183	50,588,056	0.009808	147,813	1,450	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	412,653	27,173,221	0.015186	65,071	988	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	558,553	154,261,776	0.003621	2,672,790	9,678	73.00
74.00	07400 RENAL DIALYSIS	101,944	8,671,001	0.011757	335,576	3,945	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,477,327	25,791,599	0.057279	724	41	90.00
91.00	09100 EMERGENCY	744,981	73,292,539	0.010164	12,134	123	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	32,354,182	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	9,349,257	1,151,182,245		10,106,293	166,250	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 INFUSION CENTER	0	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	1,069,309	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	1,069,309	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	143,066,646	0.000000	50.00
50.01	05001 ENDOSCOPY	0	0	0	18,868,420	0.000000	50.01
51.00	05100 RECOVERY ROOM	0	0	0	10,077,869	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,396,544	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,086,561	0.000000	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	18,476,481	0.000000	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	20,844,494	0.000000	55.00
55.01	05501 INFUSION CENTER	0	0	0	232,368	0.000000	55.01
56.00	05600 RADIOISOTOPE	0	0	0	15,612,820	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	125,859,121	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	30,600,361	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	69,051,548	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	156,224,313	0.000000	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,016,410	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	45,364,538	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	7,884,598	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	5,990,640	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	2,614,967	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	25,691,629	0.000000	69.00
69.01	06901 CARDIAC REHAB	0	0	0	903,058	0.000000	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	26,186,485	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	50,588,056	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,173,221	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	154,261,776	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	8,671,001	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	25,791,599	0.000000	90.00
91.00	09100 EMERGENCY	0	1,069,309	1,069,309	73,292,539	0.014590	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	32,354,182	0.000000	92.00
200.00	Total (lines 50 through 199)	0	1,069,309	1,069,309	1,151,182,245		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	196,667	0	10	0	50.00
50.01	05001 ENDOSCOPY	0.000000	11,706	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	12,755	0	1,986	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	116,403	0	402	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000	24,516	0	806	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	45,374	0	0	0	55.00
55.01	05501 INFUSION CENTER	0.000000	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	0.000000	25,712	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	355,412	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	126,935	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	68,140	0	27	0	59.00
60.00	06000 LABORATORY	0.000000	861,444	0	895	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	37,639	0	985	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	715,398	0	1,392	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,080,470	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,875,519	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	261,668	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	40,169	0	257	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	16,258	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	147,813	0	1,868	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	65,071	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,672,790	0	3	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	335,576	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	724	0	0	0	90.00
91.00	09100 EMERGENCY	0.014590	12,134	177	157	2	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		10,106,293	177	8,788	2	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/25/2020 8:03 am
Title XVIII			Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00		5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.100626	10	0	0	1	50.00
50.01	05001	ENDOSCOPY	0.196867	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.252235	1,986	0	0	501	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.213243	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208272	402	0	0	84	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.154560	806	0	0	125	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.161765	0	0	0	0	55.00
55.01	05501	INFUSION CENTER	0.150425	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.199985	0	0	0	0	56.00
57.00	05700	CT SCAN	0.037618	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062594	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084238	27	0	0	2	59.00
60.00	06000	LABORATORY	0.101285	895	0	0	91	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209857	985	0	0	207	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.117574	1,392	0	0	164	65.00
66.00	06600	PHYSICAL THERAPY	0.358241	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.396530	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.317808	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056511	257	0	0	15	69.00
69.01	06901	CARDIAC REHAB	0.716231	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071394	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341883	1,868	0	0	639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.535503	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170061	3	0	0	1	73.00
74.00	07400	RENAL DIALYSIS	0.310666	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.390056	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.252212	157	0	0	40	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530055	0	0	0	0	92.00
200.00		Subtotal (see instructions)		8,788	0	0	1,870	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		8,788	0	0	1,870	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/25/2020 8:03 am
	Title XVIII	Subprovider - IRF	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
50.01 05001 ENDOSCOPY	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01 05501 INFUSION CENTER	0	0	55.01
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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
69.01 06901 CARDIAC REHAB	0	0	69.01
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
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		84,762	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		84,762	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)		64,992	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)		22,149	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)		73,526,910	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)		73,526,910	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)		73,526,910	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)		867.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		19,213,150	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)		19,213,150	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	12,306,663	7,574	1,624.86	4,320	7,019,395	43.00
43.01 NEONATAL ICU	2,621,975	2,213	1,184.81	0	0	43.01
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)					29,034,496	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					55,267,041	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,078,435	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,439,335	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,517,770	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					51,749,271	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)					19,770	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					867.45	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					17,149,487	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am	
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	6,836,028	73,526,910	0.092973	17,149,487	1,594,439	90.00
91.00	Nursing School cost	0	73,526,910	0.000000	17,149,487	0	91.00
92.00	Allied health cost	0	73,526,910	0.000000	17,149,487	0	92.00
93.00	All other Medical Education	0	73,526,910	0.000000	17,149,487	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,016	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,016	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)		3,016	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)		1,363	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)		2,310,655	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)		2,310,655	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)		2,310,655	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)		766.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,044,235	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,044,235	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1	
		Component CCN: 15-S002				Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					144,901		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,189,136		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)					46,546		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,908		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					51,454		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,137,682		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	103,008	2,310,655	0.044580	0	0	90.00
91.00	Nursing School cost	0	2,310,655	0.000000	0	0	91.00
92.00	Allied health cost	0	2,310,655	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,310,655	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,786	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,786	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)		7,786	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)		4,740	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)		6,846,801	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)		6,846,801	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)		6,846,801	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)		879.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,168,214	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,168,214	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1	
		Component CCN: 15-T002				Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,495,256		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,663,470		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)					419,348		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					166,427		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					585,775		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,077,695		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	688,800	6,846,801	0.100602	0	0	90.00
91.00	Nursing School cost	0	6,846,801	0.000000	0	0	91.00
92.00	Allied health cost	0	6,846,801	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,846,801	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			84,762 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			84,762 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)			64,992 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			2,762 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)			2,632 15.00
16.00	Nursery days (title V or XIX only)			381 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)			73,514,433 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)			73,514,433 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)			73,514,433 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)			867.30 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,395,483 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)			2,395,483 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am		
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)	
Title XIX			Hospital		Cost			
Cost Center Description			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		3,435,576	2,632	1,305.31	381	497,323	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		12,306,663	7,574	1,624.86	0	0	43.00
43.01	NEONATAL ICU		2,621,975	2,213	1,184.81	0	0	43.01
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)						3,069,610	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						5,962,416	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						19,770	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						867.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						17,146,521	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	6,836,028	73,514,433	0.092989	17,146,521	1,594,438	90.00
91.00	Nursing School cost	0	73,514,433	0.000000	17,146,521	0	91.00
92.00	Allied health cost	0	73,514,433	0.000000	17,146,521	0	92.00
93.00	All other Medical Education	0	73,514,433	0.000000	17,146,521	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,016 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,016 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)			3,016 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)			0 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)			2,632 15.00
16.00	Nursery days (title V or XIX only)			381 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)			2,310,655 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)			2,310,655 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)			2,310,655 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)			766.13 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			0 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)			0 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1	
				Component CCN: 15-S002	Date/Time Prepared: 6/25/2020 8:03 am		
				Title XIX	Subprovider - IPF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1.00	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	103,008	2,310,655	0.044580	0	0	90.00
91.00	Nursing School cost	0	2,310,655	0.000000	0	0	91.00
92.00	Allied health cost	0	2,310,655	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,310,655	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,786 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,786 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)			7,786 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)			139 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)			2,632 15.00
16.00	Nursery days (title V or XIX only)			381 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)			6,846,801 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)			6,846,801 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)			6,846,801 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)			879.37 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			122,232 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)			122,232 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1	
				Component CCN: 15-T002	Date/Time Prepared: 6/25/2020 8:03 am		
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					71,698		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					193,930		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 6/25/2020 8:03 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	688,800	6,846,801	0.100602	0	0	90.00
91.00	Nursing School cost	0	6,846,801	0.000000	0	0	91.00
92.00	Allied health cost	0	6,846,801	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,846,801	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/25/2020 8:03 am	
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		22,714,112	30.00
31.00	03100	INTENSIVE CARE UNIT		9,810,709	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.100626	22,382,919	50.00
50.01	05001	ENDOSCOPY	0.196867	1,546,537	50.01
51.00	05100	RECOVERY ROOM	0.252235	1,346,196	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.213243	28,747	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208272	4,304,967	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.154560	1,634,949	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.161765	409,243	55.00
55.01	05501	INFUSION CENTER	0.150425	0	55.01
56.00	05600	RADIOISOTOPE	0.199985	2,230,007	56.00
57.00	05700	CT SCAN	0.037618	17,838,425	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062594	4,845,029	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084238	10,210,786	59.00
60.00	06000	LABORATORY	0.101285	21,630,168	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209857	3,597,929	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.117574	14,113,407	65.00
66.00	06600	PHYSICAL THERAPY	0.358241	1,708,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.396530	1,094,240	67.00
68.00	06800	SPEECH PATHOLOGY	0.317808	885,957	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056511	5,782,054	69.00
69.01	06901	CARDIAC REHAB	0.716231	283	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071394	2,950,616	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341883	8,419,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.535503	5,433,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170061	33,883,399	73.00
74.00	07400	RENAL DIALYSIS	0.310666	3,498,938	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.390056	137,234	90.00
91.00	09100	EMERGENCY	0.252212	6,407,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530055	3,452,088	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		179,773,906	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)		179,773,906	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		2,258,665	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.100626	0	50.00
50.01	05001	ENDOSCOPY	0.196867	0	50.01
51.00	05100	RECOVERY ROOM	0.252235	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.213243	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208272	19,661	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.154560	12,946	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.161765	0	55.00
55.01	05501	INFUSION CENTER	0.150425	0	55.01
56.00	05600	RADIOISOTOPE	0.199985	2,083	56.00
57.00	05700	CT SCAN	0.037618	56,361	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062594	21,601	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084238	12,023	59.00
60.00	06000	LABORATORY	0.101285	200,627	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209857	16,696	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.117574	4,233	65.00
66.00	06600	PHYSICAL THERAPY	0.358241	2,902	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.396530	1,448	67.00
68.00	06800	SPEECH PATHOLOGY	0.317808	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056511	47,368	69.00
69.01	06901	CARDIAC REHAB	0.716231	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071394	2,085	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341883	9,395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.535503	1,986	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170061	539,721	73.00
74.00	07400	RENAL DIALYSIS	0.310666	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.390056	0	90.00
91.00	09100	EMERGENCY	0.252212	35,996	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530055	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		987,132	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)		987,132	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		409	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		4,446,528	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.100626	196,667	50.00
50.01	05001	ENDOSCOPY	0.196867	11,706	50.01
51.00	05100	RECOVERY ROOM	0.252235	12,755	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.213243	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208272	116,403	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.154560	24,516	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.161765	45,374	55.00
55.01	05501	INFUSION CENTER	0.150425	0	55.01
56.00	05600	RADIOISOTOPE	0.199985	25,712	56.00
57.00	05700	CT SCAN	0.037618	355,412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062594	126,935	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084238	68,140	59.00
60.00	06000	LABORATORY	0.101285	861,444	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209857	37,639	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.117574	715,398	65.00
66.00	06600	PHYSICAL THERAPY	0.358241	2,080,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.396530	1,875,519	67.00
68.00	06800	SPEECH PATHOLOGY	0.317808	261,668	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056511	40,169	69.00
69.01	06901	CARDIAC REHAB	0.716231	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071394	16,258	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341883	147,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.535503	65,071	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170061	2,672,790	73.00
74.00	07400	RENAL DIALYSIS	0.310666	335,576	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.390056	724	90.00
91.00	09100	EMERGENCY	0.252212	12,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530055	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,106,293	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)		10,106,293	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/25/2020 8:03 am	
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		2,614,637	30.00
31.00	03100	INTENSIVE CARE UNIT		578,866	31.00
31.01	03101	NEONATAL ICU		597,120	31.01
40.00	04000	SUBPROVIDER - IPF		125,025	40.00
41.00	04100	SUBPROVIDER - IRF		128,660	41.00
43.00	04300	NURSERY		276,505	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.100626	3,025,963	50.00
50.01	05001	ENDOSCOPY	0.196867	133,864	50.01
51.00	05100	RECOVERY ROOM	0.252235	156,314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.213243	826,594	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208272	303,344	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.154560	183,914	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.161765	33,017	55.00
55.01	05501	INFUSION CENTER	0.150425	0	55.01
56.00	05600	RADIOISOTOPE	0.199985	156,672	56.00
57.00	05700	CT SCAN	0.037618	1,444,479	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062594	377,462	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084238	994,538	59.00
60.00	06000	LABORATORY	0.101285	2,527,146	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209857	45,123	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.117574	1,344,858	65.00
66.00	06600	PHYSICAL THERAPY	0.358241	150,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.396530	111,972	67.00
68.00	06800	SPEECH PATHOLOGY	0.317808	58,586	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056511	375,384	69.00
69.01	06901	CARDIAC REHAB	0.716231	8,229	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071394	202,739	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341883	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.535503	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170061	3,399,527	73.00
74.00	07400	RENAL DIALYSIS	0.310666	148,683	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.390056	20,295	90.00
91.00	09100	EMERGENCY	0.252212	761,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530055	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		16,791,028	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)		16,791,028	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3	
		Component CCN: 15-T002		Date/Time Prepared: 6/25/2020 8:03 am	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		124,800	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.100626	1,982	199 50.00
50.01	05001	ENDOSCOPY	0.196867	0	0 50.01
51.00	05100	RECOVERY ROOM	0.252235	373	94 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.213243	418	507 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208272	2,773	578 54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.154560	1,036	160 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.161765	0	0 55.00
55.01	05501	INFUSION CENTER	0.150425	0	0 55.01
56.00	05600	RADIOISOTOPE	0.199985	383	77 56.00
57.00	05700	CT SCAN	0.037618	4,843	182 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062594	3,902	244 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084238	608	51 59.00
60.00	06000	LABORATORY	0.101285	18,738	1,898 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209857	1,445	303 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.117574	18,532	2,179 65.00
66.00	06600	PHYSICAL THERAPY	0.358241	59,201	21,208 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.396530	51,232	20,315 67.00
68.00	06800	SPEECH PATHOLOGY	0.317808	10,476	3,329 68.00
69.00	06900	ELECTROCARDIOLOGY	0.056511	401	23 69.00
69.01	06901	CARDIAC REHAB	0.716231	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071394	131	9 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341883	2,039	697 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.535503	83	44 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170061	108,278	18,414 73.00
74.00	07400	RENAL DIALYSIS	0.310666	3,821	1,187 74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.390056	0	0 90.00
91.00	09100	EMERGENCY	0.252212	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530055	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		290,695	71,698 200.00
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)		290,695	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		29,362,547	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,963,704	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		1,084,459	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		195,924	2.04
3.00	Managed Care Simulated Payments		19,735,495	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		383.00	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)		8.53	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		8.53	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		3.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		3.00	12.00
13.00	Total allowable FTE count for the prior year.		3.00	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.		2.93	14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.98	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		2.98	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.007781	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.007527	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.007527	21.00
22.00	IME payment adjustment (see instructions)		161,513	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		81,054	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)		-5.53	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		161,513	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		81,054	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.39	30.00
31.00	Percentage of Medicaid patient days (see instructions)		32.28	31.00
32.00	Sum of lines 30 and 31		40.67	32.00
33.00	Allowable disproportionate share percentage (see instructions)		22.77	33.00
34.00	Disproportionate share adjustment (see instructions)		2,238,647	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		5,535,062	4,631,104	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		4,139,922	1,164,102	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		5,304,024		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		48,310,818		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			48,391,872	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			3,545,145	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			86,337	52.00
53.00	Nursing and Allied Health Managed Care payment			62,903	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			93,492	58.00
59.00	Total (sum of amounts on lines 49 through 58)			52,179,749	59.00
60.00	Primary payer payments			3,467	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			52,176,282	61.00
62.00	Deductibles billed to program beneficiaries			3,850,688	62.00
63.00	Coinurance billed to program beneficiaries			513,874	63.00
64.00	Allowable bad debts (see instructions)			770,781	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			501,008	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			225,048	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			48,312,728	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)			-27,800	70.93
70.94	HRR adjustment amount (see instructions)			-562,258	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	1.00	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			47,722,670	71.00
71.01	Sequestration adjustment (see instructions)			954,453	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs				71.03
72.00	Interim payments			45,761,620	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			1,006,597	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,067,092	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/25/2020 8:03 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	29,362,547	0	29,362,547		29,362,547	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,963,704	0		9,963,704	9,963,704	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1,084,459	0	1,084,459		1,084,459	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	195,924	0		195,924	195,924	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	19,735,495	0	14,826,916	4,908,579	19,735,495	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007527	0.007527	0.007527	0.007527		5.00
6.00	IME payment adjustment (see instructions)	22.00	161,513	0	120,592	40,921	161,513	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	81,054	0	60,894	20,160	81,054	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	161,513	0	120,592	40,921	161,513	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	81,054	0	60,894	20,160	81,054	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2277	0.2277	0.2277	0.2277		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,238,647	0	1,671,463	567,184	2,238,647	11.00
11.01	Uncompensated care payments	36.00	5,304,024	0	4,139,922	1,164,102	5,304,024	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	48,310,818	0	36,378,983	11,931,835	48,310,818	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	48,391,872	0	36,439,877	11,951,995	48,391,872	15.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/25/2020 8:03 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,545,145	0	2,667,628	877,517	3,545,145	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	39,107,505	12,829,512	51,937,017	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	3,183,660	0	2,389,006	794,654	3,183,660	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	74,956	0	63,612	11,344	74,956	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0041	0.0041	0.0041	0.0041		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	13,053	0	9,795	3,258	13,053	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0859	0.0859	0.0859	0.0859		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	273,476	0	205,215	68,261	273,476	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,545,145	0	2,667,628	877,517	3,545,145	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibit 5 Date/Time Prepared: 6/25/2020 8:03 am
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		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	29,362,547	29,362,547		29,362,547	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,963,704		9,963,704	9,963,704	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1,084,459	1,084,459		1,084,459	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	195,924		195,924	195,924	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	19,735,495	14,826,916	4,908,579	19,735,495	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007527	0.007527	0.007527		5.00
6.00	IME payment adjustment (see instructions)	22.00	161,513	120,592	40,921	161,513	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	81,054	60,894	20,160	81,054	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	161,513	120,592	40,921	161,513	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	81,054	60,894	20,160	81,054	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2277	0.2277	0.2277		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,238,647	1,671,463	567,184	2,238,647	11.00
11.01	Uncompensated care payments	36.00	5,304,024	4,139,922	1,164,102	5,304,024	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	48,310,818	36,378,983	11,931,835	48,310,818	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	48,391,872	36,439,877	11,951,995	48,391,872	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,545,145	2,667,628	877,517	3,545,145	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			39,107,505	12,829,512	51,937,017	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibit 5 Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	3,183,660	2,389,006	794,654	3,183,660	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	74,956	63,612	11,344	74,956	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0041	0.0041	0.0041		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	13,053	9,795	3,258	13,053	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0859	0.0859	0.0859		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	273,476	205,215	68,261	273,476	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,545,145	2,667,628	877,517	3,545,145	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-27,800	12,668	-40,468	-27,800	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-562,258	-425,756	-136,502	-562,258	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,971	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		22,524,426	2.00
3.00	OPPS payments		20,671,817	3.00
4.00	Outlier payment (see instructions)		250,652	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		101,676	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,971	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		46,815	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)		46,815	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)		46,815	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		38,844	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)		7,971	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)		21,024,145	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,586,091	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)		17,446,025	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		30,950	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)		17,476,975	30.00
31.00	Primary payer payments		10,534	31.00
32.00	Subtotal (line 30 minus line 31)		17,466,441	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)		900,486	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		585,316	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		654,403	36.00
37.00	Subtotal (see instructions)		18,051,757	37.00
38.00	MSP-LCC reconciliation amount from PS&R		618	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		18,051,139	40.00
40.01	Sequestration adjustment (see instructions)		361,023	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		17,905,888	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-215,772	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,868	2.00
3.00	OPPS payments		568	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		2	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		570	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)		114	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)		456	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		456	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		456	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		456	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		456	40.00
40.01	Sequestration adjustment (see instructions)		9	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		445	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		2	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet E-1 Part I Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		44,836,157		16,981,654	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	12/31/2019	925,463	12/31/2019	924,234	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)		925,463		924,234	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		45,761,620		17,905,888	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		1,006,597		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		215,772	6.02	
7.00	Total Medicare program liability (see instructions)		46,768,217		17,690,116	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,042,096		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)				0 3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,042,096		0 4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		4,010		0 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		1,046,106		0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2019 To 12/31/2019		Worksheet E-1 Part I Date/Time Prepared: 6/25/2020 8:03 am	
		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					445	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		6,323,986			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)		6,323,986			445	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		28,927			2	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		6,352,913			447	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: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/25/2020 8:03 am
		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 IPSS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,164,348 1.00
2.00	Net IPF PPS Outlier Payments			3,971 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			8.263014 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,168,319 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,168,319 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,168,319 18.00
19.00	Deductibles			54,488 19.00
20.00	Subtotal (line 18 minus line 19)			1,113,831 20.00
21.00	Coinsurance			50,468 21.00
22.00	Subtotal (line 20 minus line 21)			1,063,363 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			5,487 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			3,567 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,467 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,066,930 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			525 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,067,455 31.00
31.01	Sequestration adjustment (see instructions)			21,349 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,042,096 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			4,010 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			3,971 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part III Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			5,769,202 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0822 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			362,883 3.00
4.00	Outlier Payments			387,853 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			21.331507 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			6,519,938 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			6,519,938 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			6,519,938 19.00
20.00	Deductibles			24,528 20.00
21.00	Subtotal (line 19 minus line 20)			6,495,410 21.00
22.00	Coinurance			29,900 22.00
23.00	Subtotal (line 21 minus line 22)			6,465,510 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			25,965 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			16,877 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			17,026 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,482,387 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			177 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			6,482,564 32.00
32.01	Sequestration adjustment (see instructions)			129,651 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			6,323,986 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			28,927 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			387,853 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/25/2020 8:03 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		5,962,416		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,962,416	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5,962,416	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		4,320,813		8.00
9.00	Ancillary service charges		16,791,028	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		21,111,841	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		21,111,841	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		15,149,425	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		5,962,416	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		5,962,416	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5,962,416	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		5,962,416	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		5,962,416	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		5,962,416	0	40.00
41.00	Interim payments		7,119,262	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-1,156,846	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/25/2020 8:03 am
		Title XIX	Subprovider - IPF	Cost
			Inpatient 1.00	Outpatient 2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital /SNF/NF services		0	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		0	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/25/2020 8:03 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital /SNF/NF services	193,930		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	193,930	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	193,930	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	123,560		8.00
9.00	Ancillary service charges	290,695	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	414,255	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	414,255	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	220,325	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	193,930	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	193,930	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	193,930	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	193,930	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	193,930	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	193,930	0	40.00
41.00	Interim payments	138,720	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	55,210	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 6/25/2020 8:03 am
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Title XVIII		Hospital	PPS
			1.00

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.		10.83	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)		0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA		0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)		0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)		0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)		0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)		10.83	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		3.00	6.00
7.00	Enter the lesser of line 5 or line 6		3.00	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.50	2.50	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.50	2.50	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.50		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.50		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.44		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	2.48		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	2.48		17.00
18.00	Per resident amount	87,334.14	87,334.14		18.00
19.00	Approved amount for resident costs	0	216,589	216,589	19.00

				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			87,334.14	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)			216,589	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)	32,572	16,082		26.00
27.00	Total Inpatient Days (see instructions)	85,651	85,651		27.00
28.00	Ratio of inpatient days to total inpatient days	0.380287	0.187762		28.00
29.00	Program direct GME amount	82,366	40,667	123,033	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		5,746	5,746	30.00
31.00	Net Program direct GME amount			117,287	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 6/25/2020 8:03 am
		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)		8,671,001	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)		63,119,647	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)		3,467	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		63,116,180	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		22,635,943	42.00
43.00	Primary payer payments (see instructions)		10,534	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		22,625,409	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		85,741,589	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.736121	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.263879	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		117,287	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		86,337	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		30,950	50.00

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

Provider CCN: 15-0002

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

Worksheet G

Date/Time Prepared: 6/25/2020 8:03 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	24,486,119	0	0	0	1.00
2.00	Temporary investments	603,597	0	0	0	2.00
3.00	Notes receivable	373,412	0	0	0	3.00
4.00	Accounts receivable	41,345,749	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	13,014,549	0	0	0	7.00
8.00	Prepaid expenses	5,320,362	0	0	0	8.00
9.00	Other current assets	40,401,550	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)	125,545,338	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,373,674	0	0	0	12.00
13.00	Land improvements	6,844,912	0	0	0	13.00
14.00	Accumulated depreciation	-363,779,919	0	0	0	14.00
15.00	Buildings	267,653,434	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,775,265	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	211,854,063	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	130,721,429	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	110,899,811	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	468,250	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	111,368,061	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	367,634,828	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	15,838,503	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)	2,674,296	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	22,947,998	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	41,460,797	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	56,205,056	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,659,784	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	80,864,840	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	122,325,637	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	245,309,191				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	245,309,191	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	367,634,828	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0002

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

Worksheet G-1

Date/Time Prepared:
6/25/2020 8:03 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		244,416,475		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		892,716				2.00
3.00	Total (sum of line 1 and line 2)		245,309,191		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		245,309,191		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		245,309,191		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: 15-0002

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
6/25/2020 8:03 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	77,007,284		77,007,284	1.00
2.00	SUBPROVIDER - IPF	4,966,991		4,966,991	2.00
3.00	SUBPROVIDER - IRF	7,194,491		7,194,491	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)	89,168,766		89,168,766	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	22,213,430		22,213,430	11.00
11.01	NEONATAL ICU	0		0	11.01
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)	22,213,430		22,213,430	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	111,382,196		111,382,196	17.00
18.00	Ancillary services	488,318,241	531,425,683	1,019,743,924	18.00
19.00	Outpatient services	24,331,909	107,106,411	131,438,320	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		3,536,512	3,536,512	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	PHYSICIAN REV	-1,968	-88,428	-90,396	27.00
27.01	PRO FEES	505,924	52,217,264	52,723,188	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	624,536,302	694,197,442	1,318,733,744	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		344,612,274		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)		344,612,274		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 6/25/2020 8:03 am
			1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		1,318,733,744	1.00
2.00	Less contractual allowances and discounts on patients' accounts		990,486,519	2.00
3.00	Net patient revenues (line 1 minus line 2)		328,247,225	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		344,612,274	4.00
5.00	Net income from service to patients (line 3 minus line 4)		-16,365,049	5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc		0	6.00
7.00	Income from investments		3,258,591	7.00
8.00	Revenues from telephone and other miscellaneous communication services		0	8.00
9.00	Revenue from television and radio service		0	9.00
10.00	Purchase discounts		0	10.00
11.00	Rebates and refunds of expenses		0	11.00
12.00	Parking lot receipts		0	12.00
13.00	Revenue from laundry and linen service		0	13.00
14.00	Revenue from meals sold to employees and guests		0	14.00
15.00	Revenue from rental of living quarters		0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients		0	17.00
18.00	Revenue from sale of medical records and abstracts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen		0	20.00
21.00	Rental of vending machines		0	21.00
22.00	Rental of hospital space		0	22.00
23.00	Governmental appropriations		0	23.00
24.00	OTHER INCOME		5,400,047	24.00
24.01	NON OPERATING INCOME		20,417	24.01
24.02	CHANGE IN UNREALIZED GAIN/LOSS		8,461,712	24.02
24.03	REALIZED GAIN/LOSS ON INVESTMENT SAL		544,085	24.03
24.04	GAIN/LOSS ON ASSET DISPOSAL		-213,293	24.04
25.00	Total other income (sum of lines 6-24)		17,471,559	25.00
26.00	Total (line 5 plus line 25)		1,106,510	26.00
27.00	FOUNDATION SALARY		213,794	27.00
27.01	FOUNDATION OTHER		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)		213,794	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		892,716	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0002

Period: From 01/01/2019

Worksheet H

HHA CCN: 15-7536

To 12/31/2019

Date/Time Prepared: 6/25/2020 8:03 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	496,189	0	0	394,239	890,428	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	931,980	0	0	0	931,980	6.00
7.00	Physical Therapy	472,299	0	0	0	472,299	7.00
8.00	Occupational Therapy	121,131	0	0	0	121,131	8.00
9.00	Speech Pathology	36,063	0	0	0	36,063	9.00
10.00	Medical Social Services	2,552	0	0	0	2,552	10.00
11.00	Home Health Aide	62,975	0	0	0	62,975	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,123,189	0	0	394,239	2,517,428	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-17,523	872,905	0	872,905		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	931,980	0	931,980		6.00
7.00	Physical Therapy	0	472,299	0	472,299		7.00
8.00	Occupational Therapy	0	121,131	0	121,131		8.00
9.00	Speech Pathology	0	36,063	0	36,063		9.00
10.00	Medical Social Services	0	2,552	0	2,552		10.00
11.00	Home Health Aide	0	62,975	0	62,975		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-17,523	2,499,905	0	2,499,905		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2019 To 12/31/2019		Worksheet H-1 Part I Date/Time Prepared: 6/25/2020 8:03 am	
				Home Health Agency I		PPS	
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	872,905	0	0	0	872,905	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	931,980	0	0	0	931,980	6.00
7.00	Physical Therapy	472,299	0	0	0	472,299	7.00
8.00	Occupational Therapy	121,131	0	0	0	121,131	8.00
9.00	Speech Pathology	36,063	0	0	0	36,063	9.00
10.00	Medical Social Services	2,552	0	0	0	2,552	10.00
11.00	Home Health Aide	62,975	0	0	0	62,975	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,499,905	0	0	0	2,499,905	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	872,905					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	500,019	1,431,999				6.00
7.00	Physical Therapy	253,394	725,693				7.00
8.00	Occupational Therapy	64,988	186,119				8.00
9.00	Speech Pathology	19,348	55,411				9.00
10.00	Medical Social Services	1,369	3,921				10.00
11.00	Home Health Aide	33,787	96,762				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		2,499,905				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2019 To 12/31/2019		Worksheet H-1 Part II Date/Time Prepared: 6/25/2020 8:03 am	
				Home Health Agency I		PPS	
	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-872,905	1,627,000
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	931,980
7.00	Physical Therapy	0	0	0	0	0	472,299
8.00	Occupational Therapy	0	0	0	0	0	121,131
9.00	Speech Pathology	0	0	0	0	0	36,063
10.00	Medical Social Services	0	0	0	0	0	2,552
11.00	Home Health Aide	0	0	0	0	0	62,975
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-872,905	1,627,000
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		872,905
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.536512

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2019

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2019

Part I
Date/Time Prepared:
6/25/2020 8:03 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
		BLDG & FIXT						
	0	1.00		4.00	5.01	5.02	5.03	
1.00 Administrative and General	0	0		456,378	0	11,122	8,176	1.00
2.00 Skilled Nursing Care	1,431,999	0		0	0	0	0	2.00
3.00 Physical Therapy	725,693	0		0	0	0	0	3.00
4.00 Occupational Therapy	186,119	0		0	0	0	0	4.00
5.00 Speech Pathology	55,411	0		0	0	0	0	5.00
6.00 Medical Social Services	3,921	0		0	0	0	0	6.00
7.00 Home Health Aide	96,762	0		0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0		0	0	0	0	8.00
9.00 Drugs	0	0		0	0	0	0	9.00
10.00 DME	0	0		0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0		0	0	0	0	11.00
12.00 Respiratory Therapy	0	0		0	0	0	0	12.00
13.00 Private Duty Nursing	0	0		0	0	0	0	13.00
14.00 Clinic	0	0		0	0	0	0	14.00
15.00 Health Promotion Activities	0	0		0	0	0	0	15.00
16.00 Day Care Program	0	0		0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0		0	0	0	0	17.00
18.00 Homemaker Service	0	0		0	0	0	0	18.00
19.00 All Others (specify)	0	0		0	0	0	0	19.00
19.50 Telemedicine	0	0		0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	2,499,905	0		456,378	0	11,122	8,176	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00
Cost Center Description	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
	5.04	5A.04	5.05	5.06	7.00	8.00		
1.00 Administrative and General	21,279	496,955	60,166	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	1,431,999	173,370	0	0	0	0	2.00
3.00 Physical Therapy	0	725,693	87,859	0	0	0	0	3.00
4.00 Occupational Therapy	0	186,119	22,533	0	0	0	0	4.00
5.00 Speech Pathology	0	55,411	6,709	0	0	0	0	5.00
6.00 Medical Social Services	0	3,921	475	0	0	0	0	6.00
7.00 Home Health Aide	0	96,762	11,715	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	21,279	2,996,860	362,827	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2019

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2019

Part I
Date/Time Prepared:
6/25/2020 8:03 am

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	13,872	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	13,872	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS	
		16.00	17.00	17.01	17.02	21.00	22.00	
1.00	Administrative and General	11,688	0	11,624	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	11,688	0	11,624	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2019

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2019

Part I
Date/Time Prepared: 6/25/2020 8:03 am

Home Health Agency I

PPS

Cost Center Description	PARAMED ED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	23.00	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	0	594,305	0	594,305			1.00
2.00 Skilled Nursing Care	0	1,605,369	0	1,605,369	340,432	1,945,801	2.00
3.00 Physical Therapy	0	813,552	0	813,552	172,519	986,071	3.00
4.00 Occupational Therapy	0	208,652	0	208,652	44,246	252,898	4.00
5.00 Speech Pathology	0	62,120	0	62,120	13,173	75,293	5.00
6.00 Medical Social Services	0	4,396	0	4,396	932	5,328	6.00
7.00 Home Health Aide	0	108,477	0	108,477	23,003	131,480	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	0	3,396,871	0	3,396,871	594,305	3,396,871	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.212057		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2019 To 12/31/2019	Worksheet H-2 Part II Date/Time Prepared: 6/25/2020 8:03 am
			Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMINISTRATIVE (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	0	2,121,771	0	0	102,874	3,536,512	3,536,512	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	2,121,771	0	0	102,874	3,536,512	3,536,512	20.00
21.00 Total cost to be allocated	0	456,378	0	0	11,122	8,176	21,279	21.00
22.00 Unit cost multiplier	0.000000	0.215093	0.000000	0.108113	0.002312	0.006017		22.00

Cost Center Description	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)							
								5A.05	5.05	5.06	7.00	8.00	9.00
								1.00 Administrative and General	0	496,955	0	0	0
2.00 Skilled Nursing Care	0	1,431,999	0	0	0	0	2.00						
3.00 Physical Therapy	0	725,693	0	0	0	0	3.00						
4.00 Occupational Therapy	0	186,119	0	0	0	0	4.00						
5.00 Speech Pathology	0	55,411	0	0	0	0	5.00						
6.00 Medical Social Services	0	3,921	0	0	0	0	6.00						
7.00 Home Health Aide	0	96,762	0	0	0	0	7.00						
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00						
9.00 Drugs	0	0	0	0	0	0	9.00						
10.00 DME	0	0	0	0	0	0	10.00						
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00						
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00						
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00						
14.00 Clinic	0	0	0	0	0	0	14.00						
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00						
16.00 Day Care Program	0	0	0	0	0	0	16.00						
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00						
18.00 Homemaker Service	0	0	0	0	0	0	18.00						
19.00 All Others (specify)	0	0	0	0	0	0	19.00						
19.50 Telemedicine	0	0	0	0	0	0	19.50						
20.00 Total (sum of lines 1-19)		2,996,860	0	0	0	0	20.00						
21.00 Total cost to be allocated		362,827	0	0	0	0	21.00						
22.00 Unit cost multiplier		0.121069	0.000000	0.000000	0.000000	0.000000	22.00						

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2019 To 12/31/2019	Worksheet H-2 Part II Date/Time Prepared: 6/25/2020 8:03 am
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	31,345	3,536,512	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	31,345	3,536,512	20.00
21.00	Total cost to be allocated	0	0	0	0	13,872	11,688	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.442559	0.003305	22.00

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PROGRAM (ASSIGNED TIME)	
		17.00	17.01	17.02	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	23.00	
					21.00	22.00		
1.00	Administrative and General	0	2,202	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,202	0	0	0	0	20.00
21.00	Total cost to be allocated	0	11,624	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	5.278837	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2019	Worksheet H-3
		HHA CCN: 15-7536	To 12/31/2019	Part I Date/Time Prepared: 6/25/2020 8:03 am

Title XVIII			Home Health Agency I	PPS
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Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,945,801		1,945,801	12,254	158.79	1.00
2.00	Physical Therapy	3.00	986,071	0	986,071	5,463	180.50	2.00
3.00	Occupational Therapy	4.00	252,898	0	252,898	1,369	184.73	3.00
4.00	Speech Pathology	5.00	75,293	0	75,293	272	276.81	4.00
5.00	Medical Social Services	6.00	5,328		5,328	30	177.60	5.00
6.00	Home Health Aide	7.00	131,480		131,480	2,368	55.52	6.00
7.00	Total (sum of lines 1-6)		3,396,871	0	3,396,871	21,756		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits			Ratio (col. 3 ÷ col. 4)
			Part A	Part B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
0	1.00	2.00	3.00	4.00	5.00	

Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0	3,682		8.00
9.00	Physical Therapy		23844	0	1,839		9.00
10.00	Occupational Therapy		23844	0	431		10.00
11.00	Speech Pathology		23844	0	80		11.00
12.00	Medical Social Services		23844	0	8		12.00
13.00	Home Health Aide		23844	0	723		13.00
14.00	Total (sum of lines 8-13)			0	6,763		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (From HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00		8.00	9.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	3,682		0	584,665	1.00
2.00	Physical Therapy	0	1,839		0	331,940	2.00
3.00	Occupational Therapy	0	431		0	79,619	3.00
4.00	Speech Pathology	0	80		0	22,145	4.00
5.00	Medical Social Services	0	8		0	1,421	5.00
6.00	Home Health Aide	0	723		0	40,141	6.00
7.00	Total (sum of lines 1-6)	0	6,763		0	1,059,931	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2019 To 12/31/2019		Worksheet H-3 Part I Date/Time Prepared: 6/25/2020 8:03 am	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
9.00	Physical Therapy								9.00
10.00	Occupational Therapy								10.00
11.00	Speech Pathology								11.00
12.00	Medical Social Services								12.00
13.00	Home Health Aide								13.00
14.00	Total (sum of lines 8-13)								14.00
Program Covered Charges									
Cost Center Description		Part A	Part B		Part A	Part B		Subject to Deductibles & Coinsurance	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	118,496	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	584,665							1.00
2.00	Physical Therapy	331,940							2.00
3.00	Occupational Therapy	79,619							3.00
4.00	Speech Pathology	22,145							4.00
5.00	Medical Social Services	1,421							5.00
6.00	Home Health Aide	40,141							6.00
7.00	Total (sum of lines 1-6)	1,059,931							7.00
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
9.00	Physical Therapy								9.00
10.00	Occupational Therapy								10.00
11.00	Speech Pathology								11.00
12.00	Medical Social Services								12.00
13.00	Home Health Aide								13.00
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2019 To 12/31/2019	Worksheet H-3 Part II Date/Time Prepared: 6/25/2020 8:03 am
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.358241	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.396530	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.317808	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.341883	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.170061	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2019 To 12/31/2019	Worksheet H-4 Part I-II Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	908,902
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	58,688
13.00	Total PPS Reimbursement - LUPA Episodes		0	18,287
14.00	Total PPS Reimbursement - PEP Episodes		0	16,585
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	8,590
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	29
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,011,081
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	1,011,081
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	1,011,081
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,011,081
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	1,011,081
31.01	Sequestration adjustment (see instructions)		0	20,222
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	990,860
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2019 To 12/31/2019	Worksheet H-5 Date/Time Prepared: 6/25/2020 8:03 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		990,860	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			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			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. H-4, Part II, column as appropriate, line 32)		0		990,860	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		990,859	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 6/25/2020 8:03 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,183,660	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		74,956	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)		205.07	3.00
4.00	Number of interns & residents (see instructions)		2.98	4.00
5.00	Indirect medical education percentage (see instructions)		0.41	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)		13,053	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		8.39	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		32.28	8.00
9.00	Sum of lines 7 and 8		40.67	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.59	10.00
11.00	Disproportionate share adjustment (see instructions)		273,476	11.00
12.00	Total prospective capital payments (see instructions)		3,545,145	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