

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: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 5/21/2020 10:03 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted 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: 5/21/2020 Time: 10:03 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 KING'S DAUGHTERS' HOSPITAL (15-0069) 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) JOHN PRICE
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V 1.00	Title XVIII		Title IX 5.00	Total
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	-269,748	-26,956	0	0
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
5.00 Swing bed - SNF	0	0	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
200.00 Total	0	-269,748	-26,956	0	0

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: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 10:03 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: ONE KINGS DAUGHTERS DRIVE		PO Box: 447				1.00					
2.00	City: MADISON		State: IN		Zip Code: 47250-		County: JEFFERSON					
		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		KING'S DAUGHTERS' HOSPITAL		150069	99915	1	06/17/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA		KING'S DAUGHTERS' HOSPITAL HHA		157141	99915		03/08/1985	N	P	N	12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice		KING'S DAUGHTERS'		151535	99915		09/01/1995				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		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.							N		23.00		
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.			819	640	210	42	732	89	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069			Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 10:03 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.	0	0	0	0	0			25.00	
						Urban/Rural	S	Date of Geogr		
						1.00		2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1	10/01/2019		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1			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.					01/01/2019	12/31/2019		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)					Y	Y		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	N	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.					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.								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.								58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00	
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.00	1		60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 10:03 am	
		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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 10:03 am	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00	4.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 10:03 am	
			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)			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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		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: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 10:03 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	3.00	
Miscellaneous Cost Reporting Information								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				0			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,041,300		0				118.01
					1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N			118.02
DO NOT USE THIS LINE								
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.				Y	Y		119.00 120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				Y		5.00	122.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							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								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 10:03 am	
		1.00		2.00			
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:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
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.					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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						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	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						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	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	
						169.00	
						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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 5/21/2020 10:03 am
		1.00	2.00
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 5/21/2020 10:03 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	05/18/2020			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					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	03/11/2020	Y	03/11/2020		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 5/21/2020 10:03 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCIA		GERBER	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.	502.992.3524		LGERBER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 5/21/2020 10:03 am
		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.	SENIOR MANAGER		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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/21/2020 10:03 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	76	27,740	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)		76	27,740	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		82	29,930	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	365			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)		83				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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/21/2020 10:03 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,715	1,311	9,023			1.00
2.00 HMO and other (see instructions)	1,521	784				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,715	1,311	9,023			7.00
8.00 INTENSIVE CARE UNIT	698	198	1,305			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		150	1,156			13.00
14.00 Total (see instructions)	5,413	1,659	11,484	0.00	752.14	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	3,681	382	6,781	0.00	13.65	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	31	0	31	0.00	1.22	24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	767.01	27.00
28.00 Observation Bed Days		416	2,526			28.00
29.00 Ambulance Trips	2,085					29.00
30.00 Employee discount days (see instruction)			114			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	89	152			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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/21/2020 10:03 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	1,453	427	2,972	1.00
2.00 HMO and other (see instructions)				344	295		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1,453	427	2,972	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						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: 15-0069

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

Worksheet S-3
Part II
Date/Time Prepared:
5/21/2020 10:03 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	50,626,911	422,993	51,049,904	1,595,368.00	32.00 1.00
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthesiologist Part B		307,146	0	307,146	3,317.00	92.60 3.00
4.00	Physician-Part A - Administrative		40,028	0	40,028	197.00	203.19 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non-Physician-Part B		3,168,570	0	3,168,570	18,934.00	167.35 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		19,875,793	73,473	19,949,266	497,923.00	40.06 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		421,559	0	421,559	6,574.00	64.13 11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract Labor: Physician-Part A - Administrative		1,304,250	0	1,304,250	7,897.00	165.16 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,188,249	0	7,188,249		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		4,955,749	0	4,955,749		
20.00	Non-physician anesthesiologist Part A		0	0	0		
21.00	Non-physician anesthesiologist Part B		72,346	0	72,346		
22.00	Physician Part A - Administrative		9,396	0	9,396		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		735,116	0	735,116		
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		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3
Part II
Date/Time Prepared:
5/21/2020 10:03 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	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	6,526,464	422,993	6,949,457	265,786.00	27.00
28.00	Administrative & General under contract (see inst.)		862,280	0	862,280	3,195.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	566,546	0	566,546	22,192.00	30.00
31.00	Laundry & Linen Service	8.00	45,976	0	45,976	3,851.00	31.00
32.00	Housekeeping	9.00	718,776	0	718,776	56,605.00	32.00
33.00	Housekeeping under contract (see instructions)		228,583	0	228,583	11,200.00	33.00
34.00	Dietary	10.00	705,190	-260,089	445,101	28,142.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	260,089	260,089	16,445.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	433,103	0	433,103	11,693.00	38.00
39.00	Central Services and Supply	14.00	81,424	0	81,424	5,446.00	39.00
40.00	Pharmacy	15.00	691,553	0	691,553	19,622.00	40.00
41.00	Medical Records & Medical Records Library	16.00	524,540	0	524,540	23,903.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3
Part III
Date/Time Prepared:
5/21/2020 10:03 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)	48,242,058	422,993	48,665,051	1,587,512.00	30.65	1.00
2.00	Excluded area salaries (see instructions)	19,875,793	73,473	19,949,266	497,923.00	40.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28,366,265	349,520	28,715,785	1,089,589.00	26.35	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,725,809	0	1,725,809	14,471.00	119.26	4.00
5.00	Subtotal wage-related costs (see inst.)	7,197,645	0	7,197,645	0.00	25.07	5.00
6.00	Total (sum of lines 3 thru 5)	37,289,719	349,520	37,639,239	1,104,060.00	34.09	6.00
7.00	Total overhead cost (see instructions)	11,384,435	422,993	11,807,428	468,080.00	25.23	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 5/21/2020 10:03 am
-----------------------------	-----------------------	---	---

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,853,592	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)	6,278,919	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,389,499	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	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)	168,966	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	3,266,873	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	3,007	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,960,856	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: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part V Date/Time Prepared: 5/21/2020 10:03 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	421,559	12,960,856	1.00
2.00	Hospital	421,559	12,960,856	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	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			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0069 Component CCN: 15-7141		Period: From 01/01/2019 To 12/31/2019		Worksheet S-4 Date/Time Prepared: 5/21/2020 10:03 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			JEFFERSON		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	412	0	382	794	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	308.00	0.00	289.00	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			4.98	0.00	4.98	5.00
6.00	Direct Nursing Service			5.21	0.00	5.21	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.39	0.00	2.39	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.71	0.00	0.71	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.38	0.00	0.38	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).			99915			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,481	27	75	49	1,632	21.00
22.00	Skilled Nursing Visit Charges	356,445	6,507	18,075	11,753	392,780	22.00
23.00	Physical Therapy Visits	1,481	0	34	38	1,553	23.00
24.00	Physical Therapy Visit Charges	317,959	0	7,310	8,164	333,433	24.00
25.00	Occupational Therapy Visits	383	0	2	9	394	25.00
26.00	Occupational Therapy Visit Charges	91,439	0	478	2,151	94,068	26.00
27.00	Speech Pathology Visits	13	0	1	0	14	27.00
28.00	Speech Pathology Visit Charges	3,198	0	246	0	3,444	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	79	0	0	9	88	31.00
32.00	Home Health Aide Visit Charges	11,139	0	0	1,245	12,384	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,437	27	112	105	3,681	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)	780,180	6,507	26,109	23,313	836,109	35.00
36.00	Total Number of Episodes (standard/non outlier)	286		36	9	331	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2019 To 12/31/2019	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/21/2020 10:03 am
		Hospice I		

	Unduplicated Days	Hospice I					Total (sum of cols. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	1,825	5	89	1,919	11.00
12.00	Hospice Inpatient Respite Care	12	0	0	12	12.00
13.00	Hospice General Inpatient Care	19	0	0	19	13.00
14.00	Total Hospice Days	1,856	5	89	1,950	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 5/21/2020 10:03 am
---	--	-----------------------	---	---

				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)		0.249766		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		11,981,229		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		45,351,216		6.00	
7.00	Medicaid cost (line 1 times line 6)		11,327,192		7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP		0		9.00	
10.00	Stand-alone CHIP charges		0		10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0		11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated Care (see instructions for each line)						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,159,045	434,428	2,593,473	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	539,256	434,428	973,684	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	539,256	434,428	973,684	23.00	
				1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		12,775,085		26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		204,875		27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		315,191		27.01	
28.00	Non-Medicare bad debt expense (see instructions)		12,459,894		28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,222,374		29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,196,058		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,196,058		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

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

Worksheet A
Date/Time Prepared:
5/21/2020 10:03 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		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		14,191,687		14,461,770	1.00	
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO		0	7,859	7,859	1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	2.00	
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,197,917	-277,942	13,919,975	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	6,526,464	11,894,072	-350,991	18,069,545	5.00	
7.00	00700	OPERATION OF PLANT	566,546	2,562,530	-2	3,129,074	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	45,976	359,293	405,269	405,269	8.00	
9.00	00900	HOUSEKEEPING	718,776	432,728	0	1,151,504	9.00	
10.00	01000	DIETARY	705,190	417,837	-414,196	708,831	10.00	
11.00	01100	CAFETERIA	0	0	414,196	414,196	11.00	
13.00	01300	NURSING ADMINISTRATION	433,103	1,508	434,611	434,611	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	81,424	2,136	83,560	83,560	14.00	
15.00	01500	PHARMACY	691,553	9,263,135	-8,635,969	1,318,719	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	524,540	345,800	870,340	870,340	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	307,146	307,146	19.00	
23.00	02300	RADIOLOGY SCHOOL	127,501	11,525	139,026	139,026	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,837,472	1,432,063	6,269,535	-1,586,993	4,682,542	30.00
31.00	03100	INTENSIVE CARE UNIT	1,071,288	5,667	1,076,955	-742	1,076,213	31.00
43.00	04300	NURSERY	0	0	0	512,433	512,433	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,008,317	4,843,248	6,851,565	-4,316,443	2,535,122	50.00
51.00	05100	RECOVERY ROOM	278,984	14,147	293,131	-9,674	283,457	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	656,263	656,263	52.00
53.00	05300	ANESTHESIOLOGY	1,585,409	986,619	2,572,028	-403,208	2,168,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,882,586	994,581	3,877,167	-17,648	3,859,519	54.00
54.01	03630	ULTRA SOUND	118,800	54,058	172,858	-3,886	168,972	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	68,139	192,950	261,089	-1,213	259,876	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03480	ONCOLOGY	926,070	1,425,421	2,351,491	-66,967	2,284,524	55.01
57.00	05700	CT SCAN	152,111	285,614	437,725	-15,470	422,255	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	143,640	126,543	270,183	-1,394	268,789	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,562,983	2,842,294	4,405,277	-1,425,936	2,979,341	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	278,419	278,419	0	278,419	62.00
65.00	06500	RESPIRATORY THERAPY	630,419	122,019	752,438	-81,210	671,228	65.00
66.00	06600	PHYSICAL THERAPY	1,332,876	40,312	1,373,188	-77,944	1,295,244	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,034	7,639	199,673	-2,893	196,780	67.00
68.00	06800	SPEECH PATHOLOGY	163,933	3,858	167,791	-1,986	165,805	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03610	SLEEP LAB	140,145	85,391	225,536	-7,237	218,299	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,540,075	2,540,075	71.00
71.01	07101	IV SOLUTIONS	0	0	0	93,638	93,638	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,784,199	2,784,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,037,574	10,037,574	73.00
76.00	03140	CARDIOLOGY	446,573	218,189	664,762	-21,263	643,499	76.00
76.97	07697	CARDIAC REHABILITATION	75,853	7,296	83,149	-248	82,901	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	102,607	11,464	114,071	-8,311	105,760	90.00
91.00	09100	EMERGENCY	1,737,307	1,407,295	3,144,602	-240,426	2,904,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,594,069	192,987	1,787,056	-47,867	1,739,189	95.00
101.00	10100	HOME HEALTH AGENCY	899,522	85,026	984,548	607	985,155	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	69,109	55,386	124,495	58,998	183,493	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,441,319	69,398,654	102,839,973	-334,988	102,504,985	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	91,288	1,713	93,001	0	93,001	194.00
194.01	07951	MOB	2,830,049	293,514	3,123,563	0	3,123,563	194.01
194.02	07952	PHYSICIAN CLINICS	4,873,502	1,598,122	6,471,624	-42,826	6,428,798	194.02
194.03	07953	PHYS PRAC BUS OFC	621,301	10,094	631,395	681,833	1,313,228	194.03
194.04	07954	MOB - MAIN CAMPUS	394,332	-2,956	391,376	0	391,376	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	2,811,011	227,037	3,038,048	-136,685	2,901,363	194.06
194.07	07957	KDH - MC ORTHOPEDICS	1,875,875	673,952	2,549,827	-23,001	2,526,826	194.07
194.08	07958	KDH - MC GENERAL SURGERY	1,119,168	619,539	1,738,707	0	1,738,707	194.08
194.09	07959	KDH - MC ENT	661,221	30,888	692,109	-129,058	563,051	194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019	Worksheet A Date/Time Prepared: 5/21/2020 10:03 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	
194.10	07960 KDH - MC UROLOGY	72,885	365,424	438,309	0	438,309	194.10
194.11	07961 KDH - MC OB/GYN	1,834,960	608,737	2,443,697	-15,275	2,428,422	194.11
200.00	TOTAL (SUM OF LINES 118 through 199)	50,626,911	73,824,718	124,451,629	0	124,451,629	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

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

Worksheet A
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,154,407	13,307,363	1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	7,859	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,065,353	12,854,622	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,056,028	13,013,517	5.00
7.00	00700	OPERATION OF PLANT	-28,688	3,100,386	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	405,269	8.00
9.00	00900	HOUSEKEEPING	0	1,151,504	9.00
10.00	01000	DIETARY	0	708,831	10.00
11.00	01100	CAFETERIA	-405,565	8,631	11.00
13.00	01300	NURSING ADMINISTRATION	0	434,611	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	83,560	14.00
15.00	01500	PHARMACY	0	1,318,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-215	870,125	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-307,146	0	19.00
23.00	02300	RADIOLOGY SCHOOL	-45,225	93,801	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-918,423	3,764,119	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,076,213	31.00
43.00	04300	NURSERY	0	512,433	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,535,122	50.00
51.00	05100	RECOVERY ROOM	0	283,457	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	656,263	52.00
53.00	05300	ANESTHESIOLOGY	-2,336,572	-167,752	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,870,544	1,988,975	54.00
54.01	03630	ULTRA SOUND	0	168,972	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	259,876	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
55.01	03480	ONCOLOGY	-615,125	1,669,399	55.01
57.00	05700	CT SCAN	0	422,255	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	268,789	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-96,563	2,882,778	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	278,419	62.00
65.00	06500	RESPIRATORY THERAPY	0	671,228	65.00
66.00	06600	PHYSICAL THERAPY	0	1,295,244	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	196,780	67.00
68.00	06800	SPEECH PATHOLOGY	0	165,805	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03610	SLEEP LAB	0	218,299	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,540,075	71.00
71.01	07101	IV SOLUTIONS	0	93,638	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,784,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,037,574	73.00
76.00	03140	CARDIOLOGY	0	643,499	76.00
76.97	07697	CARDIAC REHABILITATION	0	82,901	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	105,760	90.00
91.00	09100	EMERGENCY	-511,137	2,393,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-2,810	1,736,379	95.00
101.00	10100	HOME HEALTH AGENCY	0	985,155	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	183,493	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,413,801	88,091,184	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	93,001	194.00
194.01	07951	MOB	0	3,123,563	194.01
194.02	07952	PHYSICIAN CLINICS	0	6,428,798	194.02
194.03	07953	PHYS PRAC BUS OFC	0	1,313,228	194.03
194.04	07954	MOB - MAIN CAMPUS	0	391,376	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	2,901,363	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	2,526,826	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	1,738,707	194.08
194.09	07959	KDH - MC ENT	0	563,051	194.09
194.10	07960	KDH - MC UROLOGY	0	438,309	194.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet A Date/Time Prepared: 5/21/2020 10:03 am	
Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation			
			6.00	7.00			
194.11	07961	KDH - MC OB/GYN	0	2,428,422			194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	-14,413,801	110,037,828			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	260,089	154,107	1.00
	O		260,089	154,107	
B - MEDICAL IMAGING TIME					
1.00	PHYSICIAN CLINICS	194.02	13,868	0	1.00
	O		13,868	0	
C - DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01	0	7,859	1.00
	O		0	7,859	
D - NURSERY- L&D					
1.00	NURSERY	43.00	471,379	41,054	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	603,686	52,577	2.00
	O		1,075,065	93,631	
E - CRNA EXPENSE					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	307,146	0	1.00
	O		307,146	0	
F - PHYSICIAN BILLING AND COLLECTIONS					
1.00	PHYS PRAC BUS OFC	194.03	0	681,833	1.00
	O		0	681,833	
G - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	422,993	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		422,993	0	
I - MED/SURG SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,540,075	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
	O		0	2,540,075	
J - IV SOLUTIONS					
1.00	IV SOLUTIONS	71.01	0	93,638	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
	O		0	93,638	
K - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,784,199	1.00
	O		0	2,784,199	

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
L - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,037,574	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
	O		0	10,037,574	
M - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	277,942	1.00
	O		0	277,942	
N - HOME HEALTH DIRECTOR					
1.00	HOME HEALTH AGENCY	101.00	59,605	0	1.00
	O		59,605	0	
O - HOSPICE					
1.00	HOSPICE	116.00	58,998	0	1.00
	O		58,998	0	
500.00	Grand Total: Increases		2,197,764	16,670,858	500.00

RECLASSIFICATIONS

Provider CCN: 15-0069

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

Worksheet A-6

Date/Time Prepared:
5/21/2020 10:03 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	260,089	154,107	0		1.00
	O		260,089	154,107			
B - MEDICAL IMAGING TIME							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	13,868	0	0		1.00
	O		13,868	0			
C - DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	7,859	9		1.00
	O		0	7,859			
D - NURSERY- L&D							
1.00	ADULTS & PEDIATRICS	30.00	1,075,065	93,631	0		1.00
2.00	O	0.00	0	0	0		2.00
	O		1,075,065	93,631			
E - CRNA EXPENSE							
1.00	ANESTHESIOLOGY	53.00	307,146	0	0		1.00
	O		307,146	0			
F - PHYSICIAN BILLING AND COLLECTIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	681,833	0		1.00
	O		0	681,833			
G - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,280	0		1.00
2.00	PHYSICIAN CLINICS	194.02	0	56,694	0		2.00
3.00	KDH - MC FAMILY PRACTICE	194.06	0	136,685	0		3.00
4.00	KDH - MC ORTHOPEDICS	194.07	0	23,001	0		4.00
5.00	KDH - MC ENT	194.09	0	129,058	0		5.00
6.00	KDH - MC OB/GYN	194.11	0	15,275	0		6.00
	O		0	422,993			
I - MED/SURG SUPPLIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	347	0		1.00
2.00	OPERATION OF PLANT	7.00	0	2	0		2.00
3.00	PHARMACY	15.00	0	10,576	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	399,775	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	742	0		5.00
6.00	OPERATING ROOM	50.00	0	1,513,561	0		6.00
7.00	RECOVERY ROOM	51.00	0	9,139	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	61,219	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,750	0		9.00
10.00	ULTRA SOUND	54.01	0	3,456	0		10.00
11.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	1,123	0		11.00
12.00	ONCOLOGY	55.01	0	64,902	0		12.00
13.00	CT SCAN	57.00	0	15,470	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,394	0		14.00
15.00	LABORATORY	60.00	0	86,246	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	47,838	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	13,961	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	2,893	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	1,986	0		19.00
20.00	SLEEP LAB	69.01	0	7,237	0		20.00
21.00	CARDIOLOGY	76.00	0	21,263	0		21.00
22.00	CARDIAC REHABILITATION	76.97	0	248	0		22.00
23.00	CLINIC	90.00	0	8,311	0		23.00
24.00	EMERGENCY	91.00	0	229,104	0		24.00
25.00	AMBULANCE SERVICES	95.00	0	36,532	0		25.00
	O		0	2,540,075			
J - IV SOLUTIONS							
1.00	PHARMACY	15.00	0	41,706	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18,522	0		2.00
3.00	OPERATING ROOM	50.00	0	18,683	0		3.00
4.00	RECOVERY ROOM	51.00	0	535	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70	0		5.00
6.00	ONCOLOGY	55.01	0	2,065	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	26	0		7.00
8.00	EMERGENCY	91.00	0	11,322	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	709	0		9.00
	O		0	93,638			
K - IMPLANTS							
1.00	OPERATING ROOM	50.00	0	2,784,199	0		1.00
	O		0	2,784,199			

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
L - DRUGS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,524	0	1.00	
2.00	PHARMACY	15.00	0	8,583,687	0	2.00	
3.00	ANESTHESIOLOGY	53.00	0	34,843	0	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	960	0	4.00	
5.00	ULTRASOUND	54.01	0	430	0	5.00	
6.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	90	0	6.00	
7.00	LABORATORY	60.00	0	1,339,690	0	7.00	
8.00	RESPIRATORY THERAPY	65.00	0	33,346	0	8.00	
9.00	PHYSICAL THERAPY	66.00	0	4,378	0	9.00	
10.00	AMBULANCE SERVICES	95.00	0	10,626	0	10.00	
			0	10,037,574			
M - INSURANCE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	277,942	12	1.00	
			0	277,942			
N - HOME HEALTH DIRECTOR							
1.00	PHYSICAL THERAPY	66.00	59,605	0	0	1.00	
			59,605	0			
O - HOSPICE							
1.00	HOME HEALTH AGENCY	101.00	58,998	0	0	1.00	
			58,998	0			
500.00	Grand Total: Decreases		1,774,771	17,093,851		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part I
Date/Time Prepared:
5/21/2020 10:03 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,499,119	0	0	0	5,913	1.00
2.00	Land Improvements	540,656	0	0	0	44,306	2.00
3.00	Buildings and Fixtures	117,953,918	549,685	0	549,685	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	65,943,153	0	0	0	4,109,038	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	187,936,846	549,685	0	549,685	4,159,257	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	187,936,846	549,685	0	549,685	4,159,257	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,493,206	0				1.00
2.00	Land Improvements	496,350	0				2.00
3.00	Buildings and Fixtures	118,503,603	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	61,834,115	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	184,327,274	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	184,327,274	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part II
Date/Time Prepared:
5/21/2020 10:03 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	NEW CAP REL COSTS-BLDG & FIXT	8,898,588	58,127	5,212,280	0	22,692	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,898,588	58,127	5,212,280	0	22,692	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	NEW CAP REL COSTS-BLDG & FIXT	0	14,191,687				1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	14,191,687				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part III
Date/Time Prepared:
5/21/2020 10:03 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	NEW CAP REL COSTS-BLDG & FIXT	122,493,159	0	122,493,159	0.664542	0	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	61,834,115	0	61,834,115	0.335458	0	2.00
3.00	Total (sum of lines 1-2)	184,327,274	0	184,327,274	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	8,890,729	36,647	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	7,859	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,898,588	36,647	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	NEW CAP REL COSTS-BLDG & FIXT	4,079,353	277,942	22,692	0	13,307,363	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	7,859	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,079,353	277,942	22,692	0	13,315,222	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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-268,242	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - NEW CAP REL COSTS-BLDG & FIXT HHA/HO (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01		1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00		3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-21,480	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-3,441	ADMINISTRATIVE & GENERAL	5.00		7.00
8.00 Television and radio service (chapter 21)	A	-28,688	OPERATION OF PLANT	7.00		8.00
9.00 Parking lot (chapter 21)		0		0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-6,360,883				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				12.00
13.00 Laundry and linen service		0		0.00		13.00
14.00 Cafeteria-employees and guests	B	-405,565	CAFETERIA	11.00		14.00
15.00 Rental of quarters to employees and others		0		0.00		15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		16.00
17.00 Sale of drugs to other than patients		0		0.00		17.00
18.00 Sale of medical records and abstracts	B	-215	MEDICAL RECORDS & LIBRARY	16.00		18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		19.00
20.00 Vending machines		0		0.00		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		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 - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00		26.00
26.01 Depreciation - NEW CAP REL COSTS-BLDG & FIXT HHA/HO			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01		26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00		27.00
28.00 Non-physician Anesthetist	A	-307,146	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant	A	-337,659	ADULTS & PEDIATRICS	30.00		29.00

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	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 RADIOLOGY TUITION	B	-45,225		RADIOLOGY SCHOOL	23.00	0 33.00
33.01 AMBULANCE REVENUE	B	-2,677		AMBULANCE SERVICES	95.00	0 33.01
33.02 ADVERTISING	A	-203,526		ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 SELF-INSURANCE	A	-919,452		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.03
33.04 HOSPITAL ASSOCIATION FEES	A	-9,054		ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05 HAF MEDICAID	A	-3,937,701		ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 PHYSICIAN RECRUITMENT	A	-426,838		ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 PHYSICIAN LAB SALARY OFFSET	A	-96,563		LABORATORY	60.00	0 33.07
33.08 PHYSICIAN LAB BENEFIT OFFSET	A	-19,004		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.08
33.09 CRNA BENEFIT OFFSET	A	-60,446		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.09
33.10 PA BENEFIT OFFSET	A	-66,451		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.10
33.11 DONATIONS	A	-28,860		ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12 REALIZED GAIN/LOSS	B	-864,685		NEW CAP REL COSTS-BLDG & FI XT	1.00	11 33.12
33.13 OTHER ADJUSTMENTS (SPECIFY (3))			0		0.00	0 33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,413,801				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: 15-0069

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

Worksheet A-8-2

Date/Time Prepared:
5/21/2020 10:03 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	5.00	ADMINISTRATIVE & GENERAL	449,252	437,250	12,002	211,500	26	1.00
2.00	30.00	ADULTS & PEDIATRICS	580,764	580,764	0	211,500	0	2.00
3.00	53.00	ANESTHESIOLOGY	2,339,565	2,316,826	22,739	239,400	26	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,870,544	1,870,544	0	271,900	0	4.00
5.00	55.01	ONCOLOGY	641,969	587,802	54,167	211,500	264	5.00
6.00	60.00	LABORATORY	150,000	0	150,000	260,300	1,841	6.00
7.00	69.01	SLEEP LAB	13,165	0	13,165	211,500	142	7.00
8.00	91.00	EMERGENCY	1,100,083	0	1,100,083	211,500	5,792	8.00
9.00	95.00	AMBULANCE SERVICES	438	0	438	211,500	3	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,145,780	5,793,186	1,352,594		8,094	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	2,644	132	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	2,993	150	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	55.01	ONCOLOGY	26,844	1,342	0	0	0	5.00
6.00	60.00	LABORATORY	230,390	11,520	0	0	0	6.00
7.00	69.01	SLEEP LAB	14,439	722	0	0	0	7.00
8.00	91.00	EMERGENCY	588,946	29,447	0	0	0	8.00
9.00	95.00	AMBULANCE SERVICES	305	15	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			866,561	43,328	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	2,644	9,358	446,608		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	580,764		2.00
3.00	53.00	ANESTHESIOLOGY	0	2,993	19,746	2,336,572		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,870,544		4.00
5.00	55.01	ONCOLOGY	0	26,844	27,323	615,125		5.00
6.00	60.00	LABORATORY	0	230,390	0	0		6.00
7.00	69.01	SLEEP LAB	0	14,439	0	0		7.00
8.00	91.00	EMERGENCY	0	588,946	511,137	511,137		8.00
9.00	95.00	AMBULANCE SERVICES	0	305	133	133		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	866,561	567,697	6,360,883		200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Prepared: 5/21/2020 10:03 am
---	--	-----------------------	---	--

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	13,307,363	13,307,363			1.00
1.01 00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	7,859	0	7,859		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	0			0	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,854,622	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,013,517	1,564,688	0	0	5.00
7.00 00700	OPERATION OF PLANT	3,100,386	1,478,424	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	405,269	68,536	0	0	8.00
9.00 00900	HOUSEKEEPING	1,151,504	120,137	0	0	9.00
10.00 01000	DIETARY	708,831	226,285	0	0	10.00
11.00 01100	CAFETERIA	8,631	91,514	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	434,611	73,283	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	83,560	111,327	0	0	14.00
15.00 01500	PHARMACY	1,318,719	82,740	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	870,125	10,500	0	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	RADIOLOGY SCHOOL	93,801	23,768	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,764,119	1,431,211	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	1,076,213	60,194	0	0	31.00
43.00 04300	NURSERY	512,433	70,298	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,535,122	662,927	0	0	50.00
51.00 05100	RECOVERY ROOM	283,457	49,443	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	656,263	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	-167,752	4,675	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,988,975	389,824	0	0	54.00
54.01 03630	ULTRA SOUND	168,972	0	0	0	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	259,876	17,368	0	0	54.02
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
55.01 03480	ONCOLOGY	1,669,399	440,381	0	0	55.01
57.00 05700	CT SCAN	422,255	32,183	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	268,789	38,835	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	2,882,778	224,344	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	278,419	10,032	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	671,228	43,042	0	0	65.00
66.00 06600	PHYSICAL THERAPY	1,295,244	445,918	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	196,780	51,061	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	165,805	12,082	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01 03610	SLEEP LAB	218,299	30,169	0	0	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,540,075	0	0	0	71.00
71.01 07101	IV SOLUTIONS	93,638	0	0	0	71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,784,199	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	10,037,574	0	0	0	73.00
76.00 03140	CARDIOLOGY	643,499	217,440	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	82,901	25,279	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	105,760	31,284	0	0	90.00
91.00 09100	EMERGENCY	2,393,039	499,065	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	1,736,379	170,155	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	985,155	0	6,185	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	183,493	0	1,674	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	88,091,184	8,808,412	7,859	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	27,041	0	0	190.00
194.00 07950	OTHER NON-REIMBURSABLE	93,001	0	0	0	194.00
194.01 07951	MOB	3,123,563	1,892,660	0	0	194.01
194.02 07952	PHYSICIAN CLINICS	6,428,798	992,232	0	0	194.02
194.03 07953	PHYS PRAC BUS OFC	1,313,228	35,563	0	0	194.03
194.04 07954	MOB - MAIN CAMPUS	391,376	0	0	0	194.04
194.05 07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06 07956	KDH - MC FAMILY PRACTICE	2,901,363	1,551,455	0	0	194.06
194.07 07957	KDH - MC ORTHOPEDICS	2,526,826	0	0	0	194.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
194.08 07958 KDH - MC GENERAL SURGERY	1,738,707	0	0	0	286,451	194.08
194.09 07959 KDH - MC ENT	563,051	0	0	0	136,207	194.09
194.10 07960 KDH - MC UROLOGY	438,309	0	0	0	18,655	194.10
194.11 07961 KDH - MC OB/GYN	2,428,422	0	0	0	465,748	194.11
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)	110,037,828	13,307,363	7,859	0	12,854,622	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500		16,340,971				5.00
7.00	00700		4,723,817	823,848	5,547,665		7.00
8.00	00800		485,573	84,685	36,595	606,853	8.00
9.00	00900		1,455,612	253,863	64,147	0	1,773,622
10.00	01000		1,049,040	182,956	120,826	0	0
11.00	01100		166,715	29,076	48,864	0	0
13.00	01300		618,747	107,911	39,130	0	0
14.00	01400		215,727	37,623	59,443	0	16,654
15.00	01500		1,578,462	275,289	44,179	0	33,453
16.00	01600		1,014,881	176,998	5,606	0	0
19.00	01900		0	0	0	0	0
23.00	02300		150,203	26,196	12,691	0	3,548
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000		6,158,318	1,074,029	764,198	198,767	863,440
31.00	03100		1,410,603	246,013	32,141	0	48,695
43.00	04300		703,380	122,672	37,536	12,784	8,074
ANCILLARY SERVICE COST CENTERS							
50.00	05000		3,712,078	647,398	353,971	95,992	92,032
51.00	05100		404,306	70,512	26,400	13,863	0
52.00	05200		810,776	141,402	0	16,373	36,386
53.00	05300		164,094	28,618	2,496	0	0
54.00	05400		3,113,047	542,925	208,147	41,262	57,710
54.01	03630		199,379	34,772	0	4,536	15,025
54.02	03450		294,684	51,394	9,274	2,642	4,164
55.00	05500		0	0	0	0	0
55.01	03480		2,346,808	409,290	235,142	22,201	110,279
57.00	05700		493,371	86,045	17,184	20,254	6,119
58.00	05800		344,389	60,062	20,736	4,391	5,177
59.00	05900		0	0	0	0	0
60.00	06000		3,482,452	607,350	119,789	0	59,737
62.00	06200		288,451	50,307	5,357	0	0
65.00	06500		875,626	152,712	22,982	0	0
66.00	06600		2,067,056	360,501	238,099	21,893	24,438
67.00	06700		296,992	51,796	27,264	0	0
68.00	06800		219,846	38,342	6,451	0	0
69.00	06900		0	0	0	0	0
69.01	03610		284,338	49,589	16,109	1,522	23,750
71.00	07100		2,540,075	442,997	0	0	0
71.01	07101		93,638	16,331	0	0	0
72.00	07200		2,784,199	485,573	0	0	0
73.00	07300		10,037,574	1,750,541	0	0	0
76.00	03140		975,239	170,085	116,102	24,894	7,277
76.97	07697		127,595	22,253	13,498	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000		163,306	28,481	16,704	0	7,060
91.00	09100		3,336,768	581,942	266,477	109,080	128,200
92.00	09200		0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500		2,314,536	403,662	90,854	7,704	0
101.00	10100		1,221,728	213,073	52,762	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300						
116.00	11600		217,956	38,012	14,285	0	0
118.00			79,282,356	10,977,124	3,145,439	598,158	1,551,218
NONREIMBURSABLE COST CENTERS							
190.00	19000		27,041	4,716	14,438	0	0
194.00	07950		116,366	20,295	0	0	0
194.01	07951		5,740,574	1,001,173	1,010,591	1,061	0
194.02	07952		8,657,442	1,509,884	529,805	2,407	0
194.03	07953		1,507,813	262,967	18,989	0	0
194.04	07954		492,305	85,859	0	0	222,404
194.05	07955		0	0	0	0	0
194.06	07956		5,137,312	895,963	828,403	25	0
194.07	07957		3,001,069	523,395	0	534	0
194.08	07958		2,025,158	353,194	0	2,029	0
194.09	07959		699,258	121,953	0	0	0
194.10	07960		456,964	79,696	0	0	0
194.11	07961		2,894,170	504,752	0	2,639	0
200.00			0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069			Period: From 01/01/2019 To 12/31/2019		Worksheet B Part I Date/Time Prepared: 5/21/2020 10:03 am	
Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		4A	5.00	7.00	8.00	9.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	110,037,828	16,340,971	5,547,665	606,853	1,773,622	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part I Date/Time Prepared: 5/21/2020 10:03 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,352,822					10.00
11.00	01100	CAFETERIA	0	244,655				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	765,788			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,733	0	331,180		14.00
15.00	01500	PHARMACY	0	6,242	0	1,770	1,939,395	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,604	0	345	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	1,350	0	43	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,259,496	45,385	308,766	7,435	0	30.00
31.00	03100	INTENSIVE CARE UNIT	93,326	9,224	62,755	16	0	31.00
43.00	04300	NURSERY	0	4,752	32,331	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	24,014	163,383	8,648	0	50.00
51.00	05100	RECOVERY ROOM	0	2,551	17,355	141	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,086	41,406	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,075	0	589	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,412	0	3,203	0	54.00
54.01	03630	ULTRA SOUND	0	1,034	0	1,344	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	694	0	96	0	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	9,057	0	2,125	0	55.01
57.00	05700	CT SCAN	0	1,753	0	6,202	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,330	0	828	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	24,002	0	1,803	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,257	0	192	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,147	0	373	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,488	0	13	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,343	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0	1,161	0	3	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	129,818	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	4,786	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	142,295	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,817	1,939,395	73.00
76.00	03140	CARDIOLOGY	0	5,520	0	214	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,021	0	20	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	897	0	9	0	90.00
91.00	09100	EMERGENCY	0	20,547	139,792	2,167	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	23,976	0	328	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,472	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,352,822	244,655	765,788	318,095	1,939,395	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	58	0	194.00
194.01	07951	MOB	0	0	0	1,213	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	3,909	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	411	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	443	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	1,263	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	1,784	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	1,465	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	395	0	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	897	0	194.10
194.11	07961	KDH - MC OB/GYN	0	0	0	1,247	0	194.11

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
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)	1,352,822	244,655	765,788	331,180	1,939,395	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	19.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,205,434				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
23.00	02300	RADIOLOGY SCHOOL	0	194,031			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,845	0	0	10,717,679	30.00
31.00	03100	INTENSIVE CARE UNIT	12,958	0	0	1,915,731	31.00
43.00	04300	NURSERY	6,207	0	0	927,736	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	106,809	0	0	5,204,325	50.00
51.00	05100	RECOVERY ROOM	19,199	0	0	554,327	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,749	0	0	1,060,178	52.00
53.00	05300	ANESTHESIOLOGY	22,257	0	0	220,129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,551	0	194,031	4,207,288	54.00
54.01	03630	ULTRA SOUND	7,881	0	0	263,971	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	23,690	0	0	386,638	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
55.01	03480	ONCOLOGY	27,877	0	0	3,162,779	55.01
57.00	05700	CT SCAN	67,433	0	0	698,361	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,986	0	0	453,899	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	132,586	0	0	4,427,719	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,266	0	0	352,381	62.00
65.00	06500	RESPIRATORY THERAPY	29,592	0	0	1,088,361	65.00
66.00	06600	PHYSICAL THERAPY	38,265	0	0	2,764,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,825	0	0	382,378	67.00
68.00	06800	SPEECH PATHOLOGY	3,584	0	0	269,566	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03610	SLEEP LAB	7,378	0	0	383,850	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,216	0	0	3,150,106	71.00
71.01	07101	IV SOLUTIONS	5,255	0	0	120,010	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,500	0	0	3,462,567	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,444	0	0	14,046,771	73.00
76.00	03140	CARDIOLOGY	48,753	0	0	1,348,084	76.00
76.97	07697	CARDIAC REHABILITATION	2,889	0	0	167,276	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	542	0	0	216,999	90.00
91.00	09100	EMERGENCY	109,548	0	0	4,694,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	23,349	0	0	2,864,409	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,489,035	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0		0	270,253	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,205,434	0	194,031	71,272,099	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GI FT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	46,195	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	136,719	194.00
194.01	07951	MOB	0	0	0	7,754,612	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	10,703,447	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	1,790,180	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	801,011	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	6,862,966	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	3,526,782	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	2,381,846	194.08
194.09	07959	KDH - MC ENT	0	0	0	821,606	194.09

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
			16.00	19.00	23.00	24.00	25.00
194.10	07960	KDH - MC UROLOGY	0	0	0	537,557	0
194.11	07961	KDH - MC OB/GYN	0	0	0	3,402,808	0
200.00		Cross Foot Adjustments		0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,205,434	0	194,031	110,037,828	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO		1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
23.00	02300 RADIOLOGY SCHOOL		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	10,717,679	30.00
31.00	03100 INTENSIVE CARE UNIT	1,915,731	31.00
43.00	04300 NURSERY	927,736	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	5,204,325	50.00
51.00	05100 RECOVERY ROOM	554,327	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,060,178	52.00
53.00	05300 ANESTHESIOLOGY	220,129	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,207,288	54.00
54.01	03630 ULTRA SOUND	263,971	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	386,638	54.02
55.00	05500 RADIOLOGY - THERAPEUTIC	0	55.00
55.01	03480 ONCOLOGY	3,162,779	55.01
57.00	05700 CT SCAN	698,361	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	453,899	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	4,427,719	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	352,381	62.00
65.00	06500 RESPIRATORY THERAPY	1,088,361	65.00
66.00	06600 PHYSICAL THERAPY	2,764,772	66.00
67.00	06700 OCCUPATIONAL THERAPY	382,378	67.00
68.00	06800 SPEECH PATHOLOGY	269,566	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
69.01	03610 SLEEP LAB	383,850	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,150,106	71.00
71.01	07101 IV SOLUTIONS	120,010	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,462,567	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,046,771	73.00
76.00	03140 RADIOLOGY	1,348,084	76.00
76.97	07697 CARDIAC REHABILITATION	167,276	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	216,999	90.00
91.00	09100 EMERGENCY	4,694,521	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	2,864,409	95.00
101.00	10100 HOME HEALTH AGENCY	1,489,035	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	270,253	116.00
118.00	11800 SUBTOTALS (SUM OF LINES 1 through 117)	71,272,099	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	46,195	190.00
194.00	07950 OTHER NON-REIMBURSABLE	136,719	194.00
194.01	07951 MOB	7,754,612	194.01
194.02	07952 PHYSICIAN CLINICS	10,703,447	194.02
194.03	07953 PHYS PRAC BUS OFC	1,790,180	194.03
194.04	07954 MOB - MAIN CAMPUS	801,011	194.04
194.05	07955 ONCOLOGY - NONREIMBURSABLE	0	194.05
194.06	07956 KDH - MC FAMILY PRACTICE	6,862,966	194.06
194.07	07957 KDH - MC ORTHOPEDICS	3,526,782	194.07
194.08	07958 KDH - MC GENERAL SURGERY	2,381,846	194.08
194.09	07959 KDH - MC ENT	821,606	194.09
194.10	07960 KDH - MC UROLOGY	537,557	194.10
194.11	07961 KDH - MC OB/GYN	3,402,808	194.11
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Prepared: 5/21/2020 10:03 am
Cost Center Description		Total		
		26.00		
202.00	TOTAL (sum lines 118 through 201)	110,037,828		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,564,688	0	0	5.00
7.00 00700	OPERATION OF PLANT	0	1,478,424	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	68,536	0	0	8.00
9.00 00900	HOUSEKEEPING	0	120,137	0	0	9.00
10.00 01000	DIETARY	0	226,285	0	0	10.00
11.00 01100	CAFETERIA	0	91,514	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	73,283	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	111,327	0	0	14.00
15.00 01500	PHARMACY	0	82,740	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,500	0	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	RADIOLOGY SCHOOL	0	23,768	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,431,211	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	60,194	0	0	31.00
43.00 04300	NURSERY	0	70,298	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	662,927	0	0	50.00
51.00 05100	RECOVERY ROOM	0	49,443	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	4,675	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	389,824	0	0	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	17,368	0	0	54.02
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
55.01 03480	ONCOLOGY	0	440,381	0	0	55.01
57.00 05700	CT SCAN	0	32,183	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	38,835	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	224,344	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	10,032	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	43,042	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	445,918	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	51,061	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	12,082	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01 03610	SLEEP LAB	0	30,169	0	0	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
71.01 07101	IV SOLUTIONS	0	0	0	0	71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	0	217,440	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	25,279	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	31,284	0	0	90.00
91.00 09100	EMERGENCY	0	499,065	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	170,155	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	6,185	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	0	1,674	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	8,808,412	7,859	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	27,041	0	0	190.00
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01 07951	MOB	0	1,892,660	0	0	194.01
194.02 07952	PHYSICIAN CLINICS	0	992,232	0	0	194.02
194.03 07953	PHYS PRAC BUS OFC	0	35,563	0	0	194.03
194.04 07954	MOB - MAIN CAMPUS	0	0	0	0	194.04
194.05 07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06 07956	KDH - MC FAMILY PRACTICE	0	1,551,455	0	0	194.06
194.07 07957	KDH - MC ORTHOPEDICS	0	0	0	0	194.07
194.08 07958	KDH - MC GENERAL SURGERY	0	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am
-------------------------------------	--	-----------------------	---	---

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
194.09 07959 KDH - MC ENT	0	0	0	0	0	194.09
194.10 07960 KDH - MC UROLOGY	0	0	0	0	0	194.10
194.11 07961 KDH - MC OB/GYN	0	0	0	0	0	194.11
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)	0	13,307,363	7,859	0	13,315,222	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am		
Cost Center	Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,564,688			5.00
7.00	00700	OPERATION OF PLANT	0	78,883	1,557,307		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,109	10,273	86,918	8.00
9.00	00900	HOUSEKEEPING	0	24,307	18,007	0	9.00
10.00	01000	DIETARY	0	17,518	33,917	0	10.00
11.00	01100	CAFETERIA	0	2,784	13,717	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,332	10,984	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,602	16,687	0	14.00
15.00	01500	PHARMACY	0	26,359	12,402	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,947	1,574	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	2,508	3,563	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	102,838	214,521	28,467	30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,556	9,022	0	31.00
43.00	04300	NURSERY	0	11,746	10,537	1,831	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	61,988	99,365	13,749	50.00
51.00	05100	RECOVERY ROOM	0	6,752	7,411	1,986	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,539	0	2,345	52.00
53.00	05300	ANESTHESIOLOGY	0	2,740	701	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,985	58,430	5,910	54.00
54.01	03630	ULTRA SOUND	0	3,329	0	650	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	4,921	2,603	378	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	39,189	66,008	3,180	55.01
57.00	05700	CT SCAN	0	8,239	4,824	2,901	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,751	5,821	629	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	58,153	33,626	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,817	1,504	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	14,622	6,451	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,518	66,838	3,136	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,959	7,653	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,671	1,811	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0	4,748	4,522	218	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	42,417	0	0	71.00
71.01	07101	IV SOLUTIONS	0	1,564	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	46,493	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	167,660	0	0	73.00
76.00	03140	CARDIOLOGY	0	16,286	32,592	3,566	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,131	3,789	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	2,727	4,689	0	90.00
91.00	09100	EMERGENCY	0	55,721	74,804	15,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	38,650	25,504	1,103	95.00
101.00	10100	HOME HEALTH AGENCY	0	20,402	14,811	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	3,640	4,010	0	116.00
118.00	11800	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,051,101	882,971	85,672	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	452	4,053	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	1,943	0	0	194.00
194.01	07951	MOB	0	95,862	283,685	152	194.01
194.02	07952	PHYSICIAN CLINICS	0	144,571	148,724	345	194.02
194.03	07953	PHYS PRAC BUS OFC	0	25,179	5,330	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	8,221	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	85,788	232,544	4	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	50,115	0	76	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	33,818	0	291	194.08
194.09	07959	KDH - MC ENT	0	11,677	0	0	194.09
194.10	07960	KDH - MC UROLOGY	0	7,631	0	0	194.10
194.11	07961	KDH - MC OB/GYN	0	48,330	0	378	194.11

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069			Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am	
Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,564,688	1,557,307	86,918	162,451		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	277,720					10.00
11.00	01100	CAFETERIA	0	108,015				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	94,599			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	765	0	133,906		14.00
15.00	01500	PHARMACY	0	2,756	0	716	128,037	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,357	0	139	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	596	0	18	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	258,561	20,038	38,142	3,006	0	30.00
31.00	03100	INTENSIVE CARE UNIT	19,159	4,072	7,752	6	0	31.00
43.00	04300	NURSERY	0	2,098	3,994	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,602	20,183	3,497	0	50.00
51.00	05100	RECOVERY ROOM	0	1,126	2,144	57	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,687	5,115	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	916	0	238	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,129	0	1,295	0	54.00
54.01	03630	ULTRA SOUND	0	456	0	544	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	306	0	39	0	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	3,999	0	859	0	55.01
57.00	05700	CT SCAN	0	774	0	2,508	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	587	0	335	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	10,597	0	729	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,204	0	78	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,246	0	151	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	657	0	5	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	593	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0	513	0	1	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	52,491	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	1,935	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	57,533	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	735	128,037	73.00
76.00	03140	CARDIOLOGY	0	2,437	0	87	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	451	0	8	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	396	0	4	0	90.00
91.00	09100	EMERGENCY	0	9,071	17,269	876	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	10,586	0	132	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	595	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	277,720	108,015	94,599	128,617	128,037	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	23	0	194.00
194.01	07951	MOB	0	0	0	490	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	1,580	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	166	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	179	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	511	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	721	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	592	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	160	0	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	363	0	194.10
194.11	07961	KDH - MC OB/GYN	0	0	0	504	0	194.11

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069			Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	277,720	108,015	94,599	133,906	128,037		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am	
Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	19.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,517					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
23.00	02300	RADIOLOGY SCHOOL	0		30,778			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,020			2,176,890	0	30.00
31.00	03100	INTENSIVE CARE UNIT	349			128,570	0	31.00
43.00	04300	NURSERY	167			101,410	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,878			883,618	0	50.00
51.00	05100	RECOVERY ROOM	517			69,436	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209			27,228	0	52.00
53.00	05300	ANESTHESIOLOGY	600			9,870	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	769			521,628	0	54.00
54.01	03630	ULTRA SOUND	212			6,567	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	638			26,634	0	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0			0	0	55.00
55.01	03480	ONCOLOGY	751			564,468	0	55.01
57.00	05700	CT SCAN	1,817			53,806	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	458			52,890	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0			0	0	59.00
60.00	06000	LABORATORY	3,573			336,494	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	223			16,576	0	62.00
65.00	06500	RESPIRATORY THERAPY	797			68,194	0	65.00
66.00	06600	PHYSICAL THERAPY	1,031			560,076	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	130			64,465	0	67.00
68.00	06800	SPEECH PATHOLOGY	97			18,254	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0			0	0	69.00
69.01	03610	SLEEP LAB	199			42,545	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,003			95,911	0	71.00
71.01	07101	IV SOLUTIONS	142			3,641	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,361			105,387	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,588			305,020	0	73.00
76.00	03140	CARDIOLOGY	1,314			274,389	0	76.00
76.97	07697	CARDIAC REHABILITATION	78			31,736	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15			39,762	0	90.00
91.00	09100	EMERGENCY	2,952			687,123	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	629			246,759	0	95.00
101.00	10100	HOME HEALTH AGENCY	0			41,993	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0			9,324	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,517	0	0	7,570,664	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GI FT, FLOWER, COFFEE SHOP, & CANTEEN	0			31,546	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0			1,966	0	194.00
194.01	07951	MOB	0			2,272,849	0	194.01
194.02	07952	PHYSICIAN CLINICS	0			1,287,452	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0			66,238	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0			28,771	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0			0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0			1,870,302	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0			50,912	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0			34,701	0	194.08
194.09	07959	KDH - MC ENT	0			11,837	0	194.09

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am	
Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	19.00	23.00	24.00	25.00	
194.10	07960	KDH - MC UROLOGY	0			7,994		0
194.11	07961	KDH - MC OB/GYN	0			49,212		0
200.00		Cross Foot Adjustments		0	30,778	30,778		0
201.00		Negative Cost Centers	0	0	0	0		0
202.00		TOTAL (sum lines 118 through 201)	32,517	0	30,778	13,315,222		0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am
-------------------------------------	--	-----------------------	---	---

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO		1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
23.00	02300 RADIOLOGY SCHOOL		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	2,176,890	30.00
31.00	03100 INTENSIVE CARE UNIT	128,570	31.00
43.00	04300 NURSERY	101,410	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	883,618	50.00
51.00	05100 RECOVERY ROOM	69,436	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	27,228	52.00
53.00	05300 ANESTHESIOLOGY	9,870	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	521,628	54.00
54.01	03630 ULTRA SOUND	6,567	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	26,634	54.02
55.00	05500 RADIOLOGY - THERAPEUTIC	0	55.00
55.01	03480 ONCOLOGY	564,468	55.01
57.00	05700 CT SCAN	53,806	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	52,890	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	336,494	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	16,576	62.00
65.00	06500 RESPIRATORY THERAPY	68,194	65.00
66.00	06600 PHYSICAL THERAPY	560,076	66.00
67.00	06700 OCCUPATIONAL THERAPY	64,465	67.00
68.00	06800 SPEECH PATHOLOGY	18,254	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
69.01	03610 SLEEP LAB	42,545	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	95,911	71.00
71.01	07101 IV SOLUTIONS	3,641	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	105,387	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	305,020	73.00
76.00	03140 RADIOLOGY	274,389	76.00
76.97	07697 CARDIAC REHABILITATION	31,736	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	39,762	90.00
91.00	09100 EMERGENCY	687,123	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	246,759	95.00
101.00	10100 HOME HEALTH AGENCY	41,993	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	9,324	116.00
118.00	11800 SUBTOTALS (SUM OF LINES 1 through 117)	7,570,664	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	31,546	190.00
194.00	07950 OTHER NON-REIMBURSABLE	1,966	194.00
194.01	07951 MOB	2,272,849	194.01
194.02	07952 PHYSICIAN CLINICS	1,287,452	194.02
194.03	07953 PHYS PRAC BUS OFC	66,238	194.03
194.04	07954 MOB - MAIN CAMPUS	28,771	194.04
194.05	07955 ONCOLOGY - NONREIMBURSABLE	0	194.05
194.06	07956 KDH - MC FAMILY PRACTICE	1,870,302	194.06
194.07	07957 KDH - MC ORTHOPEDICS	50,912	194.07
194.08	07958 KDH - MC GENERAL SURGERY	34,701	194.08
194.09	07959 KDH - MC ENT	11,837	194.09
194.10	07960 KDH - MC UROLOGY	7,994	194.10
194.11	07961 KDH - MC OB/GYN	49,212	194.11
200.00	Cross Foot Adjustments	30,778	200.00
201.00	Negative Cost Centers	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 5/21/2020 10:03 am
Cost Center Description		Total		
		26.00		
202.00	TOTAL (sum lines 118 through 201)	13,315,222	202.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	370,078				1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	3,492			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			373,570		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	50,223,202		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,514	0	43,514	6,887,177	-16,340,971
7.00	00700	OPERATION OF PLANT	41,115	0	41,115	566,546	0
8.00	00800	LAUNDRY & LINEN SERVICE	1,906	0	1,906	45,976	0
9.00	00900	HOUSEKEEPING	3,341	0	3,341	718,776	0
10.00	01000	DIETARY	6,293	0	6,293	445,101	0
11.00	01100	CAFETERIA	2,545	0	2,545	260,089	0
13.00	01300	NURSING ADMINISTRATION	2,038	0	2,038	433,103	0
14.00	01400	CENTRAL SERVICES & SUPPLY	3,096	0	3,096	81,424	0
15.00	01500	PHARMACY	2,301	0	2,301	691,553	0
16.00	01600	MEDICAL RECORDS & LIBRARY	292	0	292	524,540	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	RADIOLOGY SCHOOL	661	0	661	127,501	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,802	0	39,802	3,762,407	0
31.00	03100	INTENSIVE CARE UNIT	1,674	0	1,674	1,071,288	0
43.00	04300	NURSERY	1,955	0	1,955	471,379	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,436	0	18,436	2,008,317	0
51.00	05100	RECOVERY ROOM	1,375	0	1,375	278,984	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	603,686	0
53.00	05300	ANESTHESIOLOGY	130	0	130	1,278,263	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,841	0	10,841	2,868,718	0
54.01	03630	ULTRA SOUND	0	0	0	118,800	0
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	483	0	483	68,139	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0
55.01	03480	ONCOLOGY	12,247	0	12,247	926,070	0
57.00	05700	CT SCAN	895	0	895	152,111	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	0	1,080	143,640	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	6,239	0	6,239	1,466,420	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	279	0	279	0	0
65.00	06500	RESPIRATORY THERAPY	1,197	0	1,197	630,419	0
66.00	06600	PHYSICAL THERAPY	12,401	0	12,401	1,273,271	0
67.00	06700	OCCUPATIONAL THERAPY	1,420	0	1,420	192,034	0
68.00	06800	SPEECH PATHOLOGY	336	0	336	163,933	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03610	SLEEP LAB	839	0	839	140,145	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
71.01	07101	IV SOLUTIONS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03140	CARDIOLOGY	6,047	0	6,047	446,573	0
76.97	07697	CARDIAC REHABILITATION	703	0	703	75,853	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	870	0	870	102,607	0
91.00	09100	EMERGENCY	13,879	0	13,879	1,737,307	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	4,732	0	4,732	1,594,069	0
101.00	10100	HOME HEALTH AGENCY	0	2,748	2,748	900,129	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	744	744	128,107	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	244,962	3,492	248,454	33,384,455	-16,340,971
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	752	0	752	0	0
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	91,288	0
194.01	07951	MOB	52,635	0	52,635	2,830,049	0
194.02	07952	PHYSICIAN CLINICS	27,594	0	27,594	4,830,676	0
194.03	07953	PHYS PRAC BUS OFC	989	0	989	621,301	0
194.04	07954	MOB - MAIN CAMPUS	0	0	0	394,332	0
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0
194.06	07956	KDH - MC FAMILY PRACTICE	43,146	0	43,146	2,674,326	0
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	1,852,874	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	1,119,168	0	194.08
194.09 07959 KDH - MC ENT	0	0	0	532,163	0	194.09
194.10 07960 KDH - MC UROLOGY	0	0	0	72,885	0	194.10
194.11 07961 KDH - MC OB/GYN	0	0	0	1,819,685	0	194.11
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)	13,307,363	7,859	0	12,854,622		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	35.958266	2.250573	0.000000	0.255950		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)				0.000000		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: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCU. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	93,696,857				5.00
7.00	00700	OPERATION OF PLANT	4,723,817	288,941			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	485,573	1,906	413,926		8.00
9.00	00900	HOUSEKEEPING	1,455,612	3,341	0	48,989	9.00
10.00	01000	DIETARY	1,049,040	6,293	0	0	47,618
11.00	01100	CAFETERIA	166,715	2,545	0	0	0
13.00	01300	NURSING ADMINISTRATION	618,747	2,038	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	215,727	3,096	0	460	0
15.00	01500	PHARMACY	1,578,462	2,301	0	924	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,014,881	292	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	RADIOLOGY SCHOOL	150,203	661	0	98	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,158,318	39,802	135,575	23,849	44,333
31.00	03100	INTENSIVE CARE UNIT	1,410,603	1,674	0	1,345	3,285
43.00	04300	NURSERY	703,380	1,955	8,720	223	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,712,078	18,436	65,475	2,542	0
51.00	05100	RECOVERY ROOM	404,306	1,375	9,456	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	810,776	0	11,168	1,005	0
53.00	05300	ANESTHESIOLOGY	164,094	130	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,113,047	10,841	28,144	1,594	0
54.01	03630	ULTRA SOUND	199,379	0	3,094	415	0
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	294,684	483	1,802	115	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0
55.01	03480	ONCOLOGY	2,346,808	12,247	15,143	3,046	0
57.00	05700	CT SCAN	493,371	895	13,815	169	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	344,389	1,080	2,995	143	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	3,482,452	6,239	0	1,650	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	288,451	279	0	0	0
65.00	06500	RESPIRATORY THERAPY	875,626	1,197	0	0	0
66.00	06600	PHYSICAL THERAPY	2,067,056	12,401	14,933	675	0
67.00	06700	OCCUPATIONAL THERAPY	296,992	1,420	0	0	0
68.00	06800	SPEECH PATHOLOGY	219,846	336	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03610	SLEEP LAB	284,338	839	1,038	656	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,540,075	0	0	0	0
71.01	07101	IV SOLUTIONS	93,638	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,784,199	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	10,037,574	0	0	0	0
76.00	03140	CARDIOLOGY	975,239	6,047	16,980	201	0
76.97	07697	CARDIAC REHABILITATION	127,595	703	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	163,306	870	0	195	0
91.00	09100	EMERGENCY	3,336,768	13,879	74,402	3,541	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,314,536	4,732	5,255	0	0
101.00	10100	HOME HEALTH AGENCY	1,221,728	2,748	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	217,956	744	0	0	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,941,385	163,825	407,995	42,846	47,618
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	27,041	752	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE	116,366	0	0	0	0
194.01	07951	MOB	5,740,574	52,635	724	0	0
194.02	07952	PHYSICIAN CLINICS	8,657,442	27,594	1,642	0	0
194.03	07953	PHYS PRAC BUS OFC	1,507,813	989	0	0	0
194.04	07954	MOB - MAIN CAMPUS	492,305	0	0	6,143	0
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0
194.06	07956	KDH - MC FAMILY PRACTICE	5,137,312	43,146	17	0	0
194.07	07957	KDH - MC ORTHOPEDICS	3,001,069	0	364	0	0
194.08	07958	KDH - MC GENERAL SURGERY	2,025,158	0	1,384	0	0
194.09	07959	KDH - MC ENT	699,258	0	0	0	0
194.10	07960	KDH - MC UROLOGY	456,964	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
194.11	07961 KDH - MC OB/GYN	2,894,170	0	1,800	0	0	194.11
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	16,340,971	5,547,665	606,853	1,773,622	1,352,822	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.174403	19.199992	1.466091	36.204495	28.409887	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,564,688	1,557,307	86,918	162,451	277,720	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.016699	5.389706	0.209984	3.316071	5.832248	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: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	769,024					11.00
13.00	01300	0	353,799				13.00
14.00	01400	5,446	0	6,479,980			14.00
15.00	01500	19,622	0	34,633	100		15.00
16.00	01600	23,903	0	6,748	0	280,019,463	16.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	4,245	0	849	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	142,652	142,652	145,478	0	8,790,903	30.00
31.00	03100	28,993	28,993	313	0	3,009,989	31.00
43.00	04300	14,937	14,937	0	0	1,441,732	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	75,484	75,484	169,216	0	24,810,414	50.00
51.00	05100	8,018	8,018	2,753	0	4,459,589	51.00
52.00	05200	19,130	19,130	0	0	1,799,931	52.00
53.00	05300	6,523	0	11,531	6,523	5,170,083	53.00
54.00	05400	57,876	0	62,663	0	6,631,943	54.00
54.01	03630	3,250	0	26,305	0	1,830,655	54.01
54.02	03450	2,181	0	1,870	0	5,502,953	54.02
55.00	05500	0	0	0	0	0	55.00
55.01	03480	28,469	0	41,579	0	6,475,570	55.01
57.00	05700	5,511	0	121,351	0	15,663,943	57.00
58.00	05800	4,181	0	16,202	0	3,945,731	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	75,447	0	35,287	0	30,798,051	60.00
62.00	06200	0	0	0	0	1,920,068	62.00
65.00	06500	22,812	0	3,762	0	6,873,955	65.00
66.00	06600	44,469	0	7,293	0	8,888,497	66.00
67.00	06700	4,676	0	263	0	1,120,867	67.00
68.00	06800	4,222	0	0	0	832,433	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03610	3,649	0	56	0	1,713,855	69.01
71.00	07100	0	0	2,540,075	0	8,644,924	71.00
71.01	07101	0	0	93,638	0	1,220,672	71.01
72.00	07200	0	0	2,784,199	0	11,730,531	72.00
73.00	07300	0	0	35,552	100	73,750,136	73.00
76.00	03140	17,352	0	4,191	0	11,324,733	76.00
76.97	07697	3,208	0	382	0	671,096	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,818	0	178	0	125,948	90.00
91.00	09100	64,585	64,585	42,402	0	25,446,581	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	75,365	0	6,409	0	5,423,680	95.00
101.00	10100	0	0	28,794	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	8	0	0	116.00
118.00		769,024	353,799	6,223,980	100	280,019,463	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	1,129	0	0	194.00
194.01	07951	0	0	23,728	0	0	194.01
194.02	07952	0	0	76,478	0	0	194.02
194.03	07953	0	0	8,049	0	0	194.03
194.04	07954	0	0	8,662	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	24,719	0	0	194.06
194.07	07957	0	0	34,906	0	0	194.07
194.08	07958	0	0	28,657	0	0	194.08
194.09	07959	0	0	7,726	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
194.10	07960 KDH - MC UROLOGY	0	0	17,545	0	0	194.10
194.11	07961 KDH - MC OB/GYN	0	0	24,401	0	0	194.11
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)	244,655	765,788	331,180	1,939,395	1,205,434	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.318137	2.164472	0.051108	19,393.950000	0.004305	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	108,015	94,599	133,906	128,037	32,517	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.140457	0.267381	0.020665	1,280.370000	0.000116	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: 15-0069

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

Worksheet B-1
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	
		19.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
23.00	02300	RADIOLOGY SCHOOL	1,000	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,000	54.00
54.01	03630	ULTRA SOUND	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	55.00
55.01	03480	ONCOLOGY	0	55.01
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	03610	SLEEP LAB	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
71.01	07101	IV SOLUTIONS	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03140	CARDIOLOGY	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	194.00
194.01	07951	MOB	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	194.08
194.09	07959	KDH - MC ENT	0	194.09
194.10	07960	KDH - MC UROLOGY	0	194.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	
		19.00	23.00	
194.11	07961 KDH - MC OB/GYN	0	0	194.11
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	194,031	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	194.031000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	30,778	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	30.778000	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: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/21/2020 10:03 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	10,717,679		10,717,679	0	10,717,679 30.00
31.00	03100 INTENSIVE CARE UNIT	1,915,731		1,915,731	0	1,915,731 31.00
43.00	04300 NURSERY	927,736		927,736	0	927,736 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,204,325		5,204,325	0	5,204,325 50.00
51.00	05100 RECOVERY ROOM	554,327		554,327	0	554,327 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,060,178		1,060,178	0	1,060,178 52.00
53.00	05300 ANESTHESIOLOGY	220,129		220,129	19,746	239,875 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,207,288		4,207,288	0	4,207,288 54.00
54.01	03630 ULTRA SOUND	263,971		263,971	0	263,971 54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	386,638		386,638	0	386,638 54.02
55.00	05500 RADIOLOGY - THERAPEUTIC	0		0	0	0 55.00
55.01	03480 ONCOLOGY	3,162,779		3,162,779	27,323	3,190,102 55.01
57.00	05700 CT SCAN	698,361		698,361	0	698,361 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	453,899		453,899	0	453,899 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	4,427,719		4,427,719	0	4,427,719 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	352,381		352,381	0	352,381 62.00
65.00	06500 RESPIRATORY THERAPY	1,088,361	0	1,088,361	0	1,088,361 65.00
66.00	06600 PHYSICAL THERAPY	2,764,772	0	2,764,772	0	2,764,772 66.00
67.00	06700 OCCUPATIONAL THERAPY	382,378	0	382,378	0	382,378 67.00
68.00	06800 SPEECH PATHOLOGY	269,566	0	269,566	0	269,566 68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00
69.01	03610 SLEEP LAB	383,850		383,850	0	383,850 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,150,106		3,150,106	0	3,150,106 71.00
71.01	07101 IV SOLUTIONS	120,010		120,010	0	120,010 71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,462,567		3,462,567	0	3,462,567 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,046,771		14,046,771	0	14,046,771 73.00
76.00	03140 RADIOLOGY	1,348,084		1,348,084	0	1,348,084 76.00
76.97	07697 CARDIAC REHABILITATION	167,276		167,276	0	167,276 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	216,999		216,999	0	216,999 90.00
91.00	09100 EMERGENCY	4,694,521		4,694,521	511,137	5,205,658 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,344,179		2,344,179	0	2,344,179 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2,864,409		2,864,409	133	2,864,542 95.00
101.00	10100 HOME HEALTH AGENCY	1,489,035		1,489,035	0	1,489,035 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	270,253		270,253		270,253 116.00
200.00	Subtotal (see instructions)	73,616,278	0	73,616,278	558,339	74,174,617 200.00
201.00	Less Observation Beds	2,344,179		2,344,179		2,344,179 201.00
202.00	Total (see instructions)	71,272,099	0	71,272,099	558,339	71,830,438 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/21/2020 10:03 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	8,790,903		8,790,903				30.00
31.00	03100	INTENSIVE CARE UNIT	3,009,989		3,009,989				31.00
43.00	04300	NURSERY	1,441,732		1,441,732				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	5,094,893	19,715,521	24,810,414	0.209764	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,025,574	3,434,015	4,459,589	0.124300	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,778,808	21,123	1,799,931	0.589010	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,806,838	3,363,245	5,170,083	0.042577	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,202,153	5,429,790	6,631,943	0.634397	0.000000		54.00
54.01	03630	ULTRA SOUND	226,063	1,604,592	1,830,655	0.144195	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	357,293	5,145,660	5,502,953	0.070260	0.000000		54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
55.01	03480	ONCOLOGY	56,325	6,419,245	6,475,570	0.488417	0.000000		55.01
57.00	05700	CT SCAN	2,380,449	13,283,494	15,663,943	0.044584	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	262,872	3,682,859	3,945,731	0.115035	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	5,360,252	25,437,799	30,798,051	0.143766	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	996,748	923,320	1,920,068	0.183525	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	5,052,039	1,821,916	6,873,955	0.158331	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	688,531	8,199,966	8,888,497	0.311051	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	279,000	841,867	1,120,867	0.341145	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	117,522	714,911	832,433	0.323829	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
69.01	03610	SLEEP LAB	0	1,713,855	1,713,855	0.223969	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,969,081	4,675,843	8,644,924	0.364388	0.000000		71.00
71.01	07101	IV SOLUTIONS	778,899	441,773	1,220,672	0.098315	0.000000		71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,161,002	6,569,529	11,730,531	0.295176	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,621,245	55,128,891	73,750,136	0.190464	0.000000		73.00
76.00	03140	CARDIOLOGY	1,876,336	9,448,397	11,324,733	0.119039	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	752	670,344	671,096	0.249258	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	125,948	125,948	1.722925	0.000000		90.00
91.00	09100	EMERGENCY	4,573,295	20,873,286	25,446,581	0.184485	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	484,966	2,904,238	3,389,204	0.691661	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	1,223	5,422,457	5,423,680	0.528130	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	1,621,654	1,621,654				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	325,526	325,526				116.00
200.00		Subtotal (see instructions)	75,394,783	209,961,064	285,355,847				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	75,394,783	209,961,064	285,355,847				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 5/21/2020 10:03 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.209764		50.00
51.00	05100 RECOVERY ROOM	0.124300		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.589010		52.00
53.00	05300 ANESTHESIOLOGY	0.046397		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.634397		54.00
54.01	03630 ULTRA SOUND	0.144195		54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.070260		54.02
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000		55.00
55.01	03480 ONCOLOGY	0.492636		55.01
57.00	05700 CT SCAN	0.044584		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.115035		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.143766		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183525		62.00
65.00	06500 RESPIRATORY THERAPY	0.158331		65.00
66.00	06600 PHYSICAL THERAPY	0.311051		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.341145		67.00
68.00	06800 SPEECH PATHOLOGY	0.323829		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	03610 SLEEP LAB	0.223969		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364388		71.00
71.01	07101 IV SOLUTIONS	0.098315		71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.295176		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.190464		73.00
76.00	03140 RADIOLOGY	0.119039		76.00
76.97	07697 CARDIAC REHABILITATION	0.249258		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1.722925		90.00
91.00	09100 EMERGENCY	0.204572		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.691661		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.528155		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
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: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/21/2020 10:03 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,717,679		10,717,679	0	10,717,679	30.00
31.00	03100 INTENSIVE CARE UNIT	1,915,731		1,915,731	0	1,915,731	31.00
43.00	04300 NURSERY	927,736		927,736	0	927,736	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,204,325		5,204,325	0	5,204,325	50.00
51.00	05100 RECOVERY ROOM	554,327		554,327	0	554,327	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,060,178		1,060,178	0	1,060,178	52.00
53.00	05300 ANESTHESIOLOGY	220,129		220,129	19,746	239,875	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,207,288		4,207,288	0	4,207,288	54.00
54.01	03630 ULTRA SOUND	263,971		263,971	0	263,971	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	386,638		386,638	0	386,638	54.02
55.00	05500 RADIOLOGY - THERAPEUTIC	0		0	0	0	55.00
55.01	03480 ONCOLOGY	3,162,779		3,162,779	27,323	3,190,102	55.01
57.00	05700 CT SCAN	698,361		698,361	0	698,361	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	453,899		453,899	0	453,899	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	4,427,719		4,427,719	0	4,427,719	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	352,381		352,381	0	352,381	62.00
65.00	06500 RESPIRATORY THERAPY	1,088,361	0	1,088,361	0	1,088,361	65.00
66.00	06600 PHYSICAL THERAPY	2,764,772	0	2,764,772	0	2,764,772	66.00
67.00	06700 OCCUPATIONAL THERAPY	382,378	0	382,378	0	382,378	67.00
68.00	06800 SPEECH PATHOLOGY	269,566	0	269,566	0	269,566	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03610 SLEEP LAB	383,850		383,850	0	383,850	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,150,106		3,150,106	0	3,150,106	71.00
71.01	07101 IV SOLUTIONS	120,010		120,010	0	120,010	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,462,567		3,462,567	0	3,462,567	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,046,771		14,046,771	0	14,046,771	73.00
76.00	03140 RADIOLOGY	1,348,084		1,348,084	0	1,348,084	76.00
76.97	07697 CARDIAC REHABILITATION	167,276		167,276	0	167,276	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	216,999		216,999	0	216,999	90.00
91.00	09100 EMERGENCY	4,694,521		4,694,521	511,137	5,205,658	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,344,179		2,344,179		2,344,179	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	2,864,409		2,864,409	133	2,864,542	95.00
101.00	10100 HOME HEALTH AGENCY	1,489,035		1,489,035		1,489,035	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	270,253		270,253		270,253	116.00
200.00	Subtotal (see instructions)	73,616,278	0	73,616,278	558,339	74,174,617	200.00
201.00	Less Observation Beds	2,344,179		2,344,179		2,344,179	201.00
202.00	Total (see instructions)	71,272,099	0	71,272,099	558,339	71,830,438	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/21/2020 10:03 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	8,790,903		8,790,903				30.00
31.00	03100	INTENSIVE CARE UNIT	3,009,989		3,009,989				31.00
43.00	04300	NURSERY	1,441,732		1,441,732				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	5,094,893	19,715,521	24,810,414	0.209764	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,025,574	3,434,015	4,459,589	0.124300	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,778,808	21,123	1,799,931	0.589010	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,806,838	3,363,245	5,170,083	0.042577	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,202,153	5,429,790	6,631,943	0.634397	0.000000		54.00
54.01	03630	ULTRA SOUND	226,063	1,604,592	1,830,655	0.144195	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	357,293	5,145,660	5,502,953	0.070260	0.000000		54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
55.01	03480	ONCOLOGY	56,325	6,419,245	6,475,570	0.488417	0.000000		55.01
57.00	05700	CT SCAN	2,380,449	13,283,494	15,663,943	0.044584	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	262,872	3,682,859	3,945,731	0.115035	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	5,360,252	25,437,799	30,798,051	0.143766	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	996,748	923,320	1,920,068	0.183525	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	5,052,039	1,821,916	6,873,955	0.158331	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	688,531	8,199,966	8,888,497	0.311051	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	279,000	841,867	1,120,867	0.341145	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	117,522	714,911	832,433	0.323829	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
69.01	03610	SLEEP LAB	0	1,713,855	1,713,855	0.223969	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,969,081	4,675,843	8,644,924	0.364388	0.000000		71.00
71.01	07101	IV SOLUTIONS	778,899	441,773	1,220,672	0.098315	0.000000		71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,161,002	6,569,529	11,730,531	0.295176	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,621,245	55,128,891	73,750,136	0.190464	0.000000		73.00
76.00	03140	CARDIOLOGY	1,876,336	9,448,397	11,324,733	0.119039	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	752	670,344	671,096	0.249258	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	125,948	125,948	1.722925	0.000000		90.00
91.00	09100	EMERGENCY	4,573,295	20,873,286	25,446,581	0.184485	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	484,966	2,904,238	3,389,204	0.691661	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	1,223	5,422,457	5,423,680	0.528130	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	1,621,654	1,621,654				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	325,526	325,526				116.00
200.00		Subtotal (see instructions)	75,394,783	209,961,064	285,355,847				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	75,394,783	209,961,064	285,355,847				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 5/21/2020 10:03 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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		54.02
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000		55.00
55.01	03480 ONCOLOGY	0.000000		55.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
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	03610 SLEEP LAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
71.01	07101 IV SOLUTIONS	0.000000		71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03140 RADIOLOGY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
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				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
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: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part I Date/Time Prepared: 5/21/2020 10:03 am	
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)	PPS
Title XVIII		Hospital		PPS			
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,176,890	0	2,176,890	11,549	188.49	30.00
31.00	INTENSIVE CARE UNIT	128,570		128,570	1,305	98.52	31.00
43.00	NURSERY	101,410		101,410	1,156	87.72	43.00
200.00	Total (lines 30 through 199)	2,406,870		2,406,870	14,010		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,715	888,730				
31.00	INTENSIVE CARE UNIT	698	68,767				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	5,413	957,497				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 5/21/2020 10:03 am
--	--	-----------------------	---	---

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	883,618	24,810,414	0.035615	2,060,751	73,394	50.00
51.00	05100	RECOVERY ROOM	69,436	4,459,589	0.015570	380,869	5,930	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,228	1,799,931	0.015127	4,734	72	52.00
53.00	05300	ANESTHESIOLOGY	9,870	5,170,083	0.001909	442,003	844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,628	6,631,943	0.078654	753,600	59,274	54.00
54.01	03630	ULTRA SOUND	6,567	1,830,655	0.003587	106,098	381	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	26,634	5,502,953	0.004840	222,795	1,078	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	03480	ONCOLOGY	564,468	6,475,570	0.087169	41,147	3,587	55.01
57.00	05700	CT SCAN	53,806	15,663,943	0.003435	1,436,993	4,936	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	52,890	3,945,731	0.013404	149,839	2,008	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	336,494	30,798,051	0.010926	3,157,451	34,498	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	16,576	1,920,068	0.008633	599,812	5,178	62.00
65.00	06500	RESPIRATORY THERAPY	68,194	6,873,955	0.009921	3,279,543	32,536	65.00
66.00	06600	PHYSICAL THERAPY	560,076	8,888,497	0.063011	421,637	26,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,465	1,120,867	0.057514	161,265	9,275	67.00
68.00	06800	SPEECH PATHOLOGY	18,254	832,433	0.021928	81,432	1,786	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03610	SLEEP LAB	42,545	1,713,855	0.024824	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,911	8,644,924	0.011094	1,657,583	18,389	71.00
71.01	07101	IV SOLUTIONS	3,641	1,220,672	0.002983	543,911	1,622	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,387	11,730,531	0.008984	2,097,582	18,845	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	305,020	73,750,136	0.004136	9,078,747	37,550	73.00
76.00	03140	CARDIOLOGY	274,389	11,324,733	0.024229	1,162,378	28,163	76.00
76.97	07697	CARDIAC REHABILITATION	31,736	671,096	0.047290	121	6	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	39,762	125,948	0.315702	0	0	90.00
91.00	09100	EMERGENCY	687,123	25,446,581	0.027003	2,706,465	73,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	476,131	3,389,204	0.140485	365,281	51,317	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,341,849	264,742,363		30,912,037	490,320	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Prepared: 5/21/2020 10:03 am
Title XVIII		Hospital	PPS

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of 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	11,549	0.00	4,715	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,305	0.00	698	31.00	
43.00	04300	NURSERY		0	1,156	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	14,010		5,413	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 5/21/2020 10:03 am
--	-----------------------	---	---

Cost Center Description		Title XVIII						
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	PPS	
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	194,031	54.00	
54.01	03630 ULTRA SOUND	0	0	0	0	0	54.01	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.02	
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00	
55.01	03480 ONCOLOGY	0	0	0	0	0	55.01	
57.00	05700 CT SCAN	0	0	0	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000 LABORATORY	0	0	0	0	0	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
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	03610 SLEEP LAB	0	0	0	0	0	69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
71.01	07101 IV SOLUTIONS	0	0	0	0	0	71.01	
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	
76.00	03140 RADIOLOGY	0	0	0	0	0	76.00	
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00	
200.00	Total (lines 50 through 199)	0	0	0	0	194,031	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 5/21/2020 10:03 am
--	-----------------------	---------------------------------------	--

Cost Center Description		Title XVIII				Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
		4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	24,810,414	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	4,459,589	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,799,931	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	5,170,083	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	194,031	194,031	6,631,943	0.029257	54.00	
54.01	03630	ULTRA SOUND	0	0	0	1,830,655	0.000000	54.01	
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	5,502,953	0.000000	54.02	
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0.000000	55.00	
55.01	03480	ONCOLOGY	0	0	0	6,475,570	0.000000	55.01	
57.00	05700	CT SCAN	0	0	0	15,663,943	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,945,731	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00	
60.00	06000	LABORATORY	0	0	0	30,798,051	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,920,068	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,873,955	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	8,888,497	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,120,867	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	832,433	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00	
69.01	03610	SLEEP LAB	0	0	0	1,713,855	0.000000	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,644,924	0.000000	71.00	
71.01	07101	IV SOLUTIONS	0	0	0	1,220,672	0.000000	71.01	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,730,531	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73,750,136	0.000000	73.00	
76.00	03140	CARDIOLOGY	0	0	0	11,324,733	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	671,096	0.000000	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	125,948	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	25,446,581	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,389,204	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	0	194,031	194,031	264,742,363		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 5/21/2020 10:03 am
--	-----------------------	---	---

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	2,060,751	0	6,345,086	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	380,869	0	1,029,056	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	4,734	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	442,003	0	764,490	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.029257	753,600	22,048	1,443,262	42,226	54.00
54.01	03630 ULTRA SOUND	0.000000	106,098	0	369,549	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	222,795	0	2,167,425	0	54.02
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	03480 ONCOLOGY	0.000000	41,147	0	3,270,326	0	55.01
57.00	05700 CT SCAN	0.000000	1,436,993	0	4,209,654	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	149,839	0	1,270,995	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	3,157,451	0	2,804,566	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	599,812	0	294,513	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	3,279,543	0	466,065	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	421,637	0	68,084	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	161,265	0	30,995	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	81,432	0	2,191	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03610 SLEEP LAB	0.000000	0	0	52,044	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,657,583	0	1,135,379	0	71.00
71.01	07101 IV SOLUTIONS	0.000000	543,911	0	247,628	0	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,097,582	0	2,554,315	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	9,078,747	0	25,602,718	0	73.00
76.00	03140 RADIOLOGY	0.000000	1,162,378	0	3,953,764	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	121	0	365,001	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	15,388	0	90.00
91.00	09100 EMERGENCY	0.000000	2,706,465	0	4,681,249	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	365,281	0	798,064	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		30,912,037	22,048	63,941,807	42,226	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 5/21/2020 10:03 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	0.209764	6,345,086	0	0	1,330,971	50.00
51.00 05100 RECOVERY ROOM	0.124300	1,029,056	0	0	127,912	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.589010	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.042577	764,490	0	0	32,550	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.634397	1,443,262	0	0	915,601	54.00
54.01 03630 ULTRA SOUND	0.144195	369,549	0	0	53,287	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.070260	2,167,425	0	0	152,283	54.02
55.00 05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01 03480 ONCOLOGY	0.488417	3,270,326	0	0	1,597,283	55.01
57.00 05700 CT SCAN	0.044584	4,209,654	0	0	187,683	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.115035	1,270,995	0	0	146,209	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.143766	2,804,566	0	0	403,201	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183525	294,513	0	0	54,050	62.00
65.00 06500 RESPIRATORY THERAPY	0.158331	466,065	0	0	73,793	65.00
66.00 06600 PHYSICAL THERAPY	0.311051	68,084	0	0	21,178	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.341145	30,995	0	0	10,574	67.00
68.00 06800 SPEECH PATHOLOGY	0.323829	2,191	0	0	710	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01 03610 SLEEP LAB	0.223969	52,044	0	0	11,656	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364388	1,135,379	0	0	413,718	71.00
71.01 07101 IV SOLUTIONS	0.098315	247,628	0	0	24,346	71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.295176	2,554,315	0	0	753,972	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.190464	25,602,718	0	6,859	4,876,396	73.00
76.00 03140 RADIOLOGY	0.119039	3,953,764	0	0	470,652	76.00
76.97 07697 CARDIAC REHABILITATION	0.249258	365,001	0	0	90,979	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	1.722925	15,388	0	0	26,512	90.00
91.00 09100 EMERGENCY	0.184485	4,681,249	0	0	863,620	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.691661	798,064	0	0	551,990	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0.528130		0	0		95.00
200.00	Subtotal (see instructions)	63,941,807	0	6,859	13,191,126	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 - line 201)	63,941,807	0	6,859	13,191,126	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 5/21/2020 10:03 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
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 03630 ULTRA SOUND	0	0		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.02
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0		55.00
55.01 03480 ONCOLOGY	0	0		55.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
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 03610 SLEEP LAB	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
71.01 07101 IV SOLUTIONS	0	0		71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,306		73.00
76.00 03140 RADIOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
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
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	0	1,306		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	1,306		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 5/21/2020 10:03 am
--	-----------------------	---	--

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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.209764	0	0	2,521,163	0
51.00 05100 RECOVERY ROOM	0.124300	0	0	887,462	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.589010	0	0	6,056	0
53.00 05300 ANESTHESIOLOGY	0.042577	0	0	672,334	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.634397	0	0	1,038,335	0
54.01 03630 ULTRA SOUND	0.144195	0	0	368,342	0
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.070260	0	0	653,599	0
55.00 05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0
55.01 03480 ONCOLOGY	0.488417	0	0	225,458	0
57.00 05700 CT SCAN	0.044584	0	0	2,231,605	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.115035	0	0	551,934	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.143766	0	0	5,021,280	0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183525	0	0	29,085	0
65.00 06500 RESPIRATORY THERAPY	0.158331	0	0	374,063	0
66.00 06600 PHYSICAL THERAPY	0.311051	0	0	1,396,715	0
67.00 06700 OCCUPATIONAL THERAPY	0.341145	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.323829	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
69.01 03610 SLEEP LAB	0.223969	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364388	0	0	924,504	0
71.01 07101 IV SOLUTIONS	0.098315	0	0	103,961	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.295176	0	0	529,847	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.190464	0	0	5,270,696	0
76.00 03140 RADIOLOGY	0.119039	0	0	1,433,740	0
76.97 07697 CARDIAC REHABILITATION	0.249258	0	0	27,600	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	1.722925	0	0	2,907	0
91.00 09100 EMERGENCY	0.184485	0	0	6,075,675	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.691661	0	0	563,858	0
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.528130	0	0		95.00
200.00	Subtotal (see instructions)	0	0	30,910,219	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	201.00
202.00	Net Charges (line 200 - line 201)	0	0	30,910,219	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 5/21/2020 10:03 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost	
	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	528,849	50.00
51.00	05100	RECOVERY ROOM	0	110,312	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,567	52.00
53.00	05300	ANESTHESIOLOGY	0	28,626	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	658,717	54.00
54.01	03630	ULTRA SOUND	0	53,113	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	45,922	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
55.01	03480	ONCOLOGY	0	110,118	55.01
57.00	05700	CT SCAN	0	99,494	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	63,492	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	721,889	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,338	62.00
65.00	06500	RESPIRATORY THERAPY	0	59,226	65.00
66.00	06600	PHYSICAL THERAPY	0	434,450	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	03610	SLEEP LAB	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	336,878	71.00
71.01	07101	IV SOLUTIONS	0	10,221	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	156,398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,003,878	73.00
76.00	03140	CARDIOLOGY	0	170,671	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,880	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	5,009	90.00
91.00	09100	EMERGENCY	0	1,120,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	389,999	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	6,123,918	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	6,123,918	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/21/2020 10:03 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,549	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,549	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)		9,023	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)		4,715	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)		10,717,679	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)		10,717,679	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)		10,717,679	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)		928.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,375,614	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)		4,375,614	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 5/21/2020 10:03 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	1,915,731	1,305	1,467.99	698	1,024,657	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,359,845	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,760,116	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)					957,497	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					512,368	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,469,865	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,290,251	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)					2,526	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					928.02	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,344,179	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 5/21/2020 10:03 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	2,176,890	10,717,679	0.203112	2,344,179	476,131	90.00
91.00	Nursing School cost	0	10,717,679	0.000000	2,344,179	0	91.00
92.00	Allied health cost	0	10,717,679	0.000000	2,344,179	0	92.00
93.00	All other Medical Education	0	10,717,679	0.000000	2,344,179	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/21/2020 10:03 am
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,549	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,549	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)		9,023	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)		1,311	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)		1,156	15.00
16.00	Nursery days (title V or XIX only)		150	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)		10,717,679	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)		10,717,679	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)		10,717,679	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)		928.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,216,634	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)		1,216,634	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 5/21/2020 10:03 am	
Title XIX			Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	927,736	1,156	802.54	150	120,381	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,915,731	1,305	1,467.99	198	290,662	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,353,497	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,981,174	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)					2,526	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					928.02	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,344,179	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 5/21/2020 10:03 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	2,176,890	10,717,679	0.203112	2,344,179	476,131	90.00
91.00	Nursing School cost	0	10,717,679	0.000000	2,344,179	0	91.00
92.00	Allied health cost	0	10,717,679	0.000000	2,344,179	0	92.00
93.00	All other Medical Education	0	10,717,679	0.000000	2,344,179	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 5/21/2020 10:03 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	
Title XVIII Hospital PPS					
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,913,388	30.00
31.00	03100	INTENSIVE CARE UNIT		1,397,521	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.209764	2,060,751	432,271 50.00
51.00	05100	RECOVERY ROOM	0.124300	380,869	47,342 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.589010	4,734	2,788 52.00
53.00	05300	ANESTHESIOLOGY	0.046397	442,003	20,508 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.634397	753,600	478,082 54.00
54.01	03630	ULTRA SOUND	0.144195	106,098	15,299 54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.070260	222,795	15,654 54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0 55.00
55.01	03480	ONCOLOGY	0.492636	41,147	20,270 55.01
57.00	05700	CT SCAN	0.044584	1,436,993	64,067 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.115035	149,839	17,237 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.143766	3,157,451	453,934 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183525	599,812	110,080 62.00
65.00	06500	RESPIRATORY THERAPY	0.158331	3,279,543	519,253 65.00
66.00	06600	PHYSICAL THERAPY	0.311051	421,637	131,151 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341145	161,265	55,015 67.00
68.00	06800	SPEECH PATHOLOGY	0.323829	81,432	26,370 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
69.01	03610	SLEEP LAB	0.223969	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364388	1,657,583	604,003 71.00
71.01	07101	IV SOLUTIONS	0.098315	543,911	53,475 71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.295176	2,097,582	619,156 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190464	9,078,747	1,729,174 73.00
76.00	03140	CARDIOLOGY	0.119039	1,162,378	138,368 76.00
76.97	07697	CARDIAC REHABILITATION	0.249258	121	30 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.722925	0	0 90.00
91.00	09100	EMERGENCY	0.204572	2,706,465	553,667 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.691661	365,281	252,651 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50 through 94 and 96 through 98)		30,912,037	6,359,845 200.00
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)		30,912,037	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 5/21/2020 10:03 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		1,479,794	30.00
31.00	03100	INTENSIVE CARE UNIT		407,798	31.00
43.00	04300	NURSERY		839,955	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.209764	1,034,694	50.00
51.00	05100	RECOVERY ROOM	0.124300	269,509	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.589010	871,396	52.00
53.00	05300	ANESTHESIOLOGY	0.042577	542,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.634397	143,279	54.00
54.01	03630	ULTRA SOUND	0.144195	56,177	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.070260	26,280	54.02
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	55.00
55.01	03480	ONCOLOGY	0.488417	0	55.01
57.00	05700	CT SCAN	0.044584	330,081	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.115035	52,740	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.143766	943,963	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183525	70,328	62.00
65.00	06500	RESPIRATORY THERAPY	0.158331	570,088	65.00
66.00	06600	PHYSICAL THERAPY	0.311051	91,366	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341145	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.323829	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03610	SLEEP LAB	0.223969	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364388	698,642	71.00
71.01	07101	IV SOLUTIONS	0.098315	153,938	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.295176	327,250	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190464	3,479,764	73.00
76.00	03140	CARDIOLOGY	0.119039	218,253	76.00
76.97	07697	CARDIAC REHABILITATION	0.249258	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.722925	0	90.00
91.00	09100	EMERGENCY	0.184485	556,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.691661	28,790	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,465,587	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)		10,465,587	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 5/21/2020 10:03 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)		7,166,065	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,466,243	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)		9,417	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		7,187	2.04
3.00	Managed Care Simulated Payments		2,378,537	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		75.08	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	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.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	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		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.66	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.55	31.00
32.00	Sum of lines 30 and 31		26.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.84	33.00
34.00	Disproportionate share adjustment (see instructions)		261,035	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 5/21/2020 10:03 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)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000138012	0.000175732	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,110,898	1,467,465	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	830,891	368,871	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,199,762		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)	11,109,709		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	10,964,608		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		11,109,709	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		780,329	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).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		2,639	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)		22,048	58.00
59.00	Total (sum of amounts on lines 49 through 58)		11,914,725	59.00
60.00	Primary payer payments		3,218	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,911,507	61.00
62.00	Deductibles billed to program beneficiaries		1,400,612	62.00
63.00	Coinurance billed to program beneficiaries		8,866	63.00
64.00	Allowable bad debts (see instructions)		92,347	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		60,026	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		35,068	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,562,055	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)		39,523	70.93
70.94	HRR adjustment amount (see instructions)		-57,329	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 5/21/2020 10:03 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	372,651	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)	2020	168,247	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)		11,085,147	71.00
71.01	Sequestration adjustment (see instructions)		221,703	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		11,133,192	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-269,748	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,206,194	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	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 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: 15-0069

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/21/2020 10:03 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	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,166,065	0	7,166,065	7,166,065	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,466,243	0	2,466,243	2,466,243	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	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	9,417	0	9,417	9,417	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	7,187	0	7,187	7,187	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	2,378,537	0	1,745,820	632,717	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	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	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	0	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1084	0.1084	0.1084	0.1084	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	261,035	0	194,200	66,835	11.00	
11.01	Uncompensated care payments	36.00	1,199,762	0	830,891	368,871	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	11,109,709	0	8,200,573	2,909,136	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	11,109,709	0	8,200,573	2,909,136	15.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0069

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/21/2020 10:03 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	780,329	0	583,394	196,935	780,329	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	8,783,967	3,106,071	11,890,038	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	774,893	0	579,471	195,422	774,893	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	5,436	0	3,923	1,513	5,436	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	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	780,329	0	583,394	196,935	780,329	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				0.042424	0.054167		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			372,651		372,651	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				168,247	168,247	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: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/21/2020 10:03 am
---	-----------------------	---	--

		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	7,166,065	7,166,065		7,166,065	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,466,243		2,466,243	2,466,243	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	9,417	9,417		9,417	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	7,187		7,187	7,187	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,378,537	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	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	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1084	0.1084	0.1084		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	261,035	194,200	66,835	261,035	11.00
11.01	Uncompensated care payments	36.00	1,199,762	621,461	92,976	714,437	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	11,109,709	8,476,468	2,633,241	11,109,709	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	11,109,709	8,476,468	2,633,241	11,109,709	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	780,329	583,394	196,935	780,329	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			9,059,862	2,830,176	11,890,038	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/21/2020 10:03 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	774,893	579,471	195,422	774,893	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	5,436	3,923	1,513	5,436	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	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	780,329	583,394	196,935	780,329	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	372,651	372,651		372,651	27.00
28.00	Low volume adjustment prior to October 1	70.96	372,651	372,651		372,651	28.00
29.00	Low volume adjustment on or after October 1	70.97	168,247		168,247	168,247	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	39,523	21,776	17,747	39,523	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	-57,329	-57,329	0	-57,329	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: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 5/21/2020 10:03 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,306	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		13,148,900	2.00
3.00	OPPS payments		13,400,415	3.00
4.00	Outlier payment (see instructions)		10,337	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		42,226	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,306	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		6,859	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)		6,859	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)		6,859	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,553	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)		1,306	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)		13,452,978	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,532,229	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)		10,922,055	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)		10,922,055	30.00
31.00	Primary payer payments		2,955	31.00
32.00	Subtotal (line 30 minus line 31)		10,919,100	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)		222,844	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		144,849	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		129,817	36.00
37.00	Subtotal (see instructions)		11,063,949	37.00
38.00	MSP-LCC reconciliation amount from PS&R		46	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)		11,063,903	40.00
40.01	Sequestration adjustment (see instructions)		221,278	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		10,869,581	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-26,956	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		172,707	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: 15-0069		Period: From 01/01/2019 To 12/31/2019		Worksheet E-1 Part I Date/Time Prepared: 5/21/2020 10:03 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		11,133,192		10,869,581	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11,133,192		10,869,581	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		269,748		26,956	6.02	
7.00	Total Medicare program liability (see instructions)		10,863,444		10,842,625	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: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 5/21/2020 10:03 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: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 5/21/2020 10:03 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		3,981,174		1.00
2.00	Medical and other services			6,123,918	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,981,174	6,123,918	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)		3,981,174	6,123,918	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		10,465,587	30,910,219	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)		10,465,587	30,910,219	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)		10,465,587	30,910,219	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		6,484,413	24,786,301	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)		3,981,174	6,123,918	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)		3,981,174	6,123,918	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)		3,981,174	6,123,918	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3,981,174	6,123,918	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		3,981,174	6,123,918	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)		3,981,174	6,123,918	40.00
41.00	Interim payments		3,981,174	6,123,918	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-0069

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

Worksheet G
Date/Time Prepared:
5/21/2020 10:03 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	14,394,881	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,960,805	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	2,442,862	0	0	0	7.00
8.00	Prepaid expenses	4,114,174	0	0	0	8.00
9.00	Other current assets	235,176	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)	31,147,898	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,989,556	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-1,723,169	0	0	0	14.00
15.00	Buildings	118,507,606	0	0	0	15.00
16.00	Accumulated depreciation	-39,562,491	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	1,220,059	0	0	0	21.00
22.00	Accumulated depreciation	-1,025,427	0	0	0	22.00
23.00	Major movable equipment	60,610,053	0	0	0	23.00
24.00	Accumulated depreciation	-46,094,360	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)	95,921,827	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	172,480,857	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	172,480,857	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	299,550,582	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,269,496	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)	653,245	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	12,908,184	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,830,925	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	89,095,285	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	993,908	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	90,089,193	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	104,920,118	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	194,630,464				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)	194,630,464	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	299,550,582	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0069

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

Worksheet G-1

Date/Time Prepared:
5/21/2020 10:03 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		167,631,418		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		26,999,046		0		2.00
3.00	Total (sum of line 1 and line 2)		194,630,464		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)		194,630,464		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)		194,630,464		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: 15-0069

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,885,210		11,885,210	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,885,210		11,885,210	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,847,798		2,847,798	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,847,798		2,847,798	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,733,008		14,733,008	17.00
18.00	Ancillary services	62,213,279	211,588,977	273,802,256	18.00
19.00	Outpatient services	0	71,896,345	71,896,345	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		1,621,654	1,621,654	22.00
23.00	AMBULANCE SERVICES	1,223	5,449,533	5,450,756	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	325,526	325,526	26.00
27.00	OTHER OUTPATIENT	0	127,261	127,261	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	76,947,510	291,009,296	367,956,806	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		124,451,629		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)		124,451,629		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 5/21/2020 10:03 am
------------------------------------	-----------------------	---	--

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	367,956,806	1.00
2.00	Less contractual allowances and discounts on patients' accounts	246,126,557	2.00
3.00	Net patient revenues (line 1 minus line 2)	121,830,249	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	124,451,629	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,621,380	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	272,174	6.00
7.00	Income from investments	4,084,984	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	405,565	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	215	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	58,396	23.00
24.00	OTHER OPERATING INCOME	24,799,092	24.00
25.00	Total other income (sum of lines 6-24)	29,620,426	25.00
26.00	Total (line 5 plus line 25)	26,999,046	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	26,999,046	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet H

HHA CCN: 15-7141

To 12/31/2019

Date/Time Prepared: 5/21/2020 10:03 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00	899,373	149	220	0	10,636	910,378	5.00
HHA REIMBURSABLE SERVICES							
6.00	0	0	25,222	0	0	25,222	6.00
7.00	0	0	23,841	0	0	23,841	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	0	0	0	0	0	0	10.00
11.00	0	0	1,593	0	0	1,593	11.00
12.00	0	0	0	0	23,507	23,507	12.00
13.00	0	0	0	0	7	7	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
23.50	0	0	0	0	0	0	23.50
24.00	899,373	149	50,876	0	34,150	984,548	24.00
	Reclassifi cation	Reclassifi ed 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	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	-626,182	284,196	0	284,196			5.00
HHA REIMBURSABLE SERVICES							
6.00	354,536	379,758	0	379,758			6.00
7.00	196,834	220,675	0	220,675			7.00
8.00	61,383	61,383	0	61,383			8.00
9.00	2,195	2,195	0	2,195			9.00
10.00	0	0	0	0			10.00
11.00	11,841	13,434	0	13,434			11.00
12.00	0	23,507	0	23,507			12.00
13.00	0	7	0	7			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
23.50	0	0	0	0			23.50
24.00	607	985,155	0	985,155			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: 15-0069 HHA CCN: 15-7141		Period: From 01/01/2019 To 12/31/2019		Worksheet H-1 Part I Date/Time Prepared: 5/21/2020 10:03 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	284,196	0	0	0	284,196	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	379,758	0	0	0	379,758	6.00
7.00	Physical Therapy	220,675	0	0	0	220,675	7.00
8.00	Occupational Therapy	61,383	0	0	0	61,383	8.00
9.00	Speech Pathology	2,195	0	0	0	2,195	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	13,434	0	0	0	13,434	11.00
12.00	Supplies (see instructions)	23,507	0	0	0	23,507	12.00
13.00	Drugs	7	0	0	0	7	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)	985,155	0	0	0	985,155	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	284,196					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	153,968	533,726				6.00
7.00	Physical Therapy	89,470	310,145				7.00
8.00	Occupational Therapy	24,887	86,270				8.00
9.00	Speech Pathology	890	3,085				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	5,447	18,881				11.00
12.00	Supplies (see instructions)	9,531	33,038				12.00
13.00	Drugs	3	10				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)		985,155				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet H-1

HHA CCN: 15-7141

To 12/31/2019

Part II
Date/Time Prepared:
5/21/2020 10:03 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	-284,196	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	379,758	6.00
7.00	Physical Therapy	0	0	0	0	220,675	7.00
8.00	Occupational Therapy	0	0	0	0	61,383	8.00
9.00	Speech Pathology	0	0	0	0	2,195	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	13,434	11.00
12.00	Supplies (see instructions)	0	0	0	0	23,507	12.00
13.00	Drugs	0	0	0	0	7	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	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-284,196	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	284,196	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.405439	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet H-2

HHA CCN: 15-7141

To 12/31/2019

Part I
Date/Time Prepared:
5/21/2020 10:03 am

Home Health
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP			
		1.00	1.01	2.00			
	0				4.00	4A	
1.00 Administrative and General	0	0	6,185	0	230,388	236,573	1.00
2.00 Skilled Nursing Care	533,726	0	0	0	0	533,726	2.00
3.00 Physical Therapy	310,145	0	0	0	0	310,145	3.00
4.00 Occupational Therapy	86,270	0	0	0	0	86,270	4.00
5.00 Speech Pathology	3,085	0	0	0	0	3,085	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	18,881	0	0	0	0	18,881	7.00
8.00 Supplies (see instructions)	33,038	0	0	0	0	33,038	8.00
9.00 Drugs	10	0	0	0	0	10	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)	985,155	0	6,185	0	230,388	1,221,728	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
Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	5.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	41,259	52,762	0	0	0	0	1.00
2.00 Skilled Nursing Care	93,083	0	0	0	0	0	2.00
3.00 Physical Therapy	54,090	0	0	0	0	0	3.00
4.00 Occupational Therapy	15,046	0	0	0	0	0	4.00
5.00 Speech Pathology	538	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	3,293	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	5,762	0	0	0	0	0	8.00
9.00 Drugs	2	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)	213,073	52,762	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.							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: 15-0069	Period: From 01/01/2019	Worksheet H-2 Part I Date/Time Prepared: 5/21/2020 10:03 am
		HHA CCN: 15-7141	To 12/31/2019	

Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	NONPHYSICIAN	RADIOLOGY	
		ADMINISTRATIVE	SERVICES & SUPPLY		RECORDS & LIBRARY	ANESTHETISTS	SCHOOL	
		13.00	14.00	15.00	16.00	19.00	23.00	
1.00	Administrative and General	0	0	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	1,472	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	1,472	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.							21.00
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	330,594	0	330,594				1.00
2.00	Skilled Nursing Care	626,809	0	626,809	178,878	805,687		2.00
3.00	Physical Therapy	364,235	0	364,235	103,945	468,180		3.00
4.00	Occupational Therapy	101,316	0	101,316	28,913	130,229		4.00
5.00	Speech Pathology	3,623	0	3,623	1,034	4,657		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	22,174	0	22,174	6,328	28,502		7.00
8.00	Supplies (see instructions)	40,272	0	40,272	11,493	51,765		8.00
9.00	Drugs	12	0	12	3	15		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,489,035	0	1,489,035	330,594	1,489,035		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.				0.285378			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: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2019 To 12/31/2019	Worksheet H-2 Part II Date/Time Prepared: 5/21/2020 10:03 am
---	---	---	---

		Home Health Agency I	PPS
--	--	----------------------	-----

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	1.01	2.00				
1.00 Administrative and General	0	2,748	2,748	900,129	0	236,573	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	533,726	2.00
3.00 Physical Therapy	0	0	0	0	0	310,145	3.00
4.00 Occupational Therapy	0	0	0	0	0	86,270	4.00
5.00 Speech Pathology	0	0	0	0	0	3,085	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	18,881	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	33,038	8.00
9.00 Drugs	0	0	0	0	0	10	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	2,748	2,748	900,129	0	1,221,728	20.00
21.00 Total cost to be allocated	0	6,185	0	230,388	0	213,073	21.00
22.00 Unit cost multiplier	0.000000	2.250728	0.000000	0.255950	0	0.174403	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	2,748	0	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)	2,748	0	0	0	0	0	20.00
21.00 Total cost to be allocated	52,762	0	0	0	0	0	21.00
22.00 Unit cost multiplier	19.200146	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0069	Period: From 01/01/2019	Worksheet H-2 Part II Date/Time Prepared: 5/21/2020 10:03 am
	HHA CCN: 15-7141	To 12/31/2019	
		Home Health Agency I	PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)		
		14.00	15.00	16.00	19.00	23.00		
1.00	Administrative and General	0	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	28,794	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telmedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	28,794	0	0	0	0		20.00
21.00	Total cost to be allocated	1,472	0	0	0	0		21.00
22.00	Unit cost multiplier	0.051122	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2019	Worksheet H-3 Part I
		HHA CCN: 15-7141	To 12/31/2019	Date/Time Prepared: 5/21/2020 10:03 am

Title XVIII			Home Health Agency I	PPS
-------------	--	--	----------------------	-----

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	805,687		805,687	3,347	240.72	1.00
2.00	Physical Therapy	3.00	468,180	0	468,180	2,547	183.82	2.00
3.00	Occupational Therapy	4.00	130,229	0	130,229	715	182.14	3.00
4.00	Speech Pathology	5.00	4,657	0	4,657	28	166.32	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	28,502		28,502	144	197.93	6.00
7.00	Total (sum of lines 1-6)		1,437,255	0	1,437,255	6,781		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		99915	0	1,632	8.00
9.00	Physical Therapy		99915	0	1,553	9.00
10.00	Occupational Therapy		99915	0	394	10.00
11.00	Speech Pathology		99915	0	14	11.00
12.00	Medical Social Services		99915	0	0	12.00
13.00	Home Health Aide		99915	0	88	13.00
14.00	Total (sum of lines 8-13)			0	3,681	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	51,765	0	51,765	32,909	1.572974	15.00
16.00	Cost of Drugs	9.00	15	0	15	259	0.057915	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	1,632		0	392,855	1.00
2.00	Physical Therapy	0	1,553		0	285,472	2.00
3.00	Occupational Therapy	0	394		0	71,763	3.00
4.00	Speech Pathology	0	14		0	2,328	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	88		0	17,418	6.00
7.00	Total (sum of lines 1-6)	0	3,681		0	769,836	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0069 HHA CCN: 15-7141		Period: From 01/01/2019 To 12/31/2019		Worksheet H-3 Part I Date/Time Prepared: 5/21/2020 10:03 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	
Cost Center Description		Program Covered Charges			Cost of Services			
		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	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	15.00	
16.00	Cost of Drugs		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	392,855					1.00	
2.00	Physical Therapy	285,472					2.00	
3.00	Occupational Therapy	71,763					3.00	
4.00	Speech Pathology	2,328					4.00	
5.00	Medical Social Services	0					5.00	
6.00	Home Health Aide	17,418					6.00	
7.00	Total (sum of lines 1-6)	769,836					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: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2019 To 12/31/2019	Worksheet H-3 Part II Date/Time Prepared: 5/21/2020 10:03 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	0.311051	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.341145	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.323829	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.364388	0	0	col. 2, line 15.00 4.00
4.01	Cost of Medical Supplies 1	71.01	0.098315	0	0	col. 2, line 15.01 4.01
5.00	Cost of Drugs	73.00	0.190464	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2019 To 12/31/2019	Worksheet H-4 Part I-II Date/Time Prepared: 5/21/2020 10:03 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	735,992
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	2,013
13.00	Total PPS Reimbursement - LUPA Episodes		0	17,298
14.00	Total PPS Reimbursement - PEP Episodes		0	10,297
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	601
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
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	766,201
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	766,201
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	766,201
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	766,201
30.00	ZERO OUT SETTLEMENT		0	1
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	766,202
31.01	Sequestration adjustment (see instructions)		0	15,324
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	750,878
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	0
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: 15-0069	Period: From 01/01/2019	Worksheet H-5
	HHA CCN: 15-7141	To 12/31/2019	Date/Time Prepared: 5/21/2020 10:03 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		750,878	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		750,878	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		0	6.02
7.00	Total Medicare program liability (see instructions)		0		750,878	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0

Hospice CCN: 15-1535

To 12/31/2019

Date/Time Prepared: 5/21/2020 10:03 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	69,109	3,513	72,622	36,446	109,068
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	125	125	0	125
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	107	107
14.00	PHARMACY*	0	6,770	6,770	0	6,770
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0
26.00	PHYSICIAN SERVICES**	0	0	0	0	0
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	0	6,464	6,464	2,245	8,709
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	1,159	1,159	276	1,435
31.00	OCCUPATIONAL THERAPY**	0	0	0	103	103
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	0	906	906	4,993	5,899
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	3,286	3,286	14,829	18,115
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	33,162	33,162	0	33,162
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	69,109	55,385	124,494	58,999	183,493

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPI CE COSTS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0

Hospice CCN: 15-1535

To 12/31/2019

Date/Time Prepared: 5/21/2020 10:03 am

		ADJUSTMENTS	TOTAL (col . 5 ± col . 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	109,068	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	125	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	107	13.00
14.00	PHARMACY*	0	6,770	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	17.00
DI RECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	8,709	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	1,435	30.00
31.00	OCCUPATIONAL THERAPY**	0	103	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	5,899	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPI CE AIDE & HOME MAKER SERVICES**	0	18,115	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	33,162	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPI CE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	183,493	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2019 To 12/31/2019	Worksheet 0-2 Date/Time Prepared: 5/21/2020 10:03 am
--	---	---	--

	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	6,356	6,356	2,207	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	1,140	1,140	271	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	101	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	891	891	4,910	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	3,231	3,231	14,581	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	33,162	33,162	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	44,780	44,780	22,070	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS		TOTAL (col. 5 ± col. 6)	
	6.00	7.00		
DI RECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	8,563	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	1,411	30.00
31.00	OCCUPATIONAL THERAPY	0	101	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	5,801	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	17,812	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	33,162	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	66,850	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-3

Hospice CCN: 15-1535

To 12/31/2019

Date/Time Prepared: 5/21/2020 10:03 am

		Hospice I					
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	42	42	15	57	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	7	7	2	9	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	1	1	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	6	6	32	38	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	21	21	96	117	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	76	76	146	222	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	57	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	9	30.00
31.00	OCCUPATIONAL THERAPY	0	1	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	38	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	117	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	222	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 15-0069
Hospice CCN: 15-1535

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

Worksheet 0-4
Date/Time Prepared:
5/21/2020 10:03 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	66	66	23	89 28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	12	12	3	15 30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	1	1 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	9	9	51	60 33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	34	34	152	186 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	121	121	230	351 100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)
		6.00	7.00
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0
26.00	PHYSICIAN SERVICES	0	0
27.00	NURSE PRACTITIONER	0	0
28.00	REGISTERED NURSE	0	89
29.00	LPN/LVN	0	0
30.00	PHYSICAL THERAPY	0	15
31.00	OCCUPATIONAL THERAPY	0	1
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0
33.00	MEDICAL SOCIAL SERVICES	0	60
34.00	SPIRITUAL COUNSELING	0	0
35.00	DIETARY COUNSELING	0	0
36.00	COUNSELING - OTHER	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	186
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0
39.00	PATIENT TRANSPORTATION	0	0
40.00	IMAGING SERVICES	0	0
41.00	LABS & DIAGNOSTICS	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0
42.50	DRUGS CHARGED TO PATIENTS	0	0
43.00	OUTPATIENT SERVICES	0	0
44.00	PALLIATIVE RADIATION THERAPY	0	0
45.00	PALLIATIVE CHEMOTHERAPY	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0
100.00	TOTAL *	0	351

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0069
 Hospice CCN: 15-1535

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

Worksheet 0-5
 Date/Time Prepared:
 5/21/2020 10:03 am

Descriptions	Hospice I		TOTAL EXPENSES (sum of col s. 1 + 2)	
	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
	1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS				
1.00 CAP REL COSTS-BLDG & FIXT	0	1,674	1,674	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT	0	32,789	32,789	3.00
4.00 ADMINISTRATIVE & GENERAL	109,068	38,012	147,080	4.00
5.00 PLANT OPERATION & MAINTENANCE	0	14,285	14,285	5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00 HOUSEKEEPING	0	0	0	7.00
8.00 DIETARY	0	0	0	8.00
9.00 NURSING ADMINISTRATION	0	0	0	9.00
10.00 ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00 MEDICAL RECORDS	0	0	0	11.00
12.00 STAFF TRANSPORTATION	125		125	12.00
13.00 VOLUNTEER SERVICE COORDINATION	107		107	13.00
14.00 PHARMACY	6,770	0	6,770	14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00 OTHER GENERAL SERVICE	0	0	0	16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
LEVEL OF CARE				
50.00 HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00 HOSPICE ROUTINE HOME CARE	66,850		66,850	51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	222		222	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	351		351	53.00
NONREIMBURSABLE COST CENTERS				
60.00 BEREAVEMENT PROGRAM	0		0	60.00
61.00 VOLUNTEER PROGRAM	0		0	61.00
62.00 FUNDRAISING	0		0	62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00 PALLIATIVE CARE PROGRAM	0		0	64.00
65.00 OTHER PHYSICIAN SERVICES	0		0	65.00
66.00 RESIDENTIAL CARE	0		0	66.00
67.00 ADVERTISING	0		0	67.00
68.00 TELEHEALTH/TELEMONITORING	0		0	68.00
69.00 THIRFT STORE	0		0	69.00
70.00 NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00 NEGATIVE COST CENTER	0		0	99.00
100.00 TOTAL	183,493	86,760	270,253	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2019

Part I
Date/Time Prepared:
5/21/2020 10:03 am

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIX	1,674	1,674			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	32,789	0	0	32,789	3.00
4.00	ADMINISTRATIVE & GENERAL	147,080	1,674	0	22,089	170,843 4.00
5.00	PLANT OPERATION & MAINTENANCE	14,285	0	0	0	14,285 5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0 6.00
7.00	HOUSEKEEPING	0	0	0	0	0 7.00
8.00	DIETARY	0	0	0	0	0 8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0 9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0 10.00
11.00	MEDICAL RECORDS	0	0	0	0	0 11.00
12.00	STAFF TRANSPORTATION	125	0	0	0	125 12.00
13.00	VOLUNTEER SERVICE COORDINATION	107	0	0	51	158 13.00
14.00	PHARMACY	6,770	0	0	0	6,770 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0 15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0 17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	66,850			10,471	77,321 51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	222	0	0	69	291 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	351	0	0	109	460 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0 60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0 61.00
62.00	FUNDRAISING	0	0	0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0 65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0 66.00
67.00	ADVERTISING	0	0	0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0 68.00
69.00	THRIFT STORE	0	0	0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0 70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0 71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0 99.00
100.00	TOTAL	270,253	1,674	0	32,789	270,253 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2019

Part I
Date/Time Prepared:
5/21/2020 10:03 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 ADMINISTRATIVE & GENERAL	170,843					4.00
5.00 PLANT OPERATION & MAINTENANCE	24,550	38,835				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	0	0		0		7.00
8.00 DIETARY	0	0		0	0	8.00
9.00 NURSING ADMINISTRATION	0	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00 MEDICAL RECORDS	0	0		0		11.00
12.00 STAFF TRANSPORTATION	215	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	272	0		0		13.00
14.00 PHARMACY	11,635	0		0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00 OTHER GENERAL SERVICE	0	0		0		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
LEVEL OF CARE						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	132,880					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	500	15,146	0	0	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	791	23,689	0	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00 BEREAVEMENT PROGRAM	0	0		0		60.00
61.00 VOLUNTEER PROGRAM	0	0		0		61.00
62.00 FUNDRAISING	0	0		0		62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00 PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00 RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00 ADVERTISING	0	0		0		67.00
68.00 TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00 THIRFT STORE	0	0		0		69.00
70.00 NURSING FACILITY ROOM & BOARD						70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00 TOTAL	170,843	38,835	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2019	Worksheet 0-6
		Hospice CCN: 15-1535	To 12/31/2019	Part I
				Date/Time Prepared: 5/21/2020 10:03 am

Descriptions	Hospice I					
	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			10.00
11.00	MEDICAL RECORDS	0		0		11.00
12.00	STAFF TRANSPORTATION	0			340	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	430 13.00
14.00	PHARMACY	0			0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0 15.00
16.00	OTHER GENERAL SERVICE	0			0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	335	422 51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	2	4 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	3	4 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0 60.00
61.00	VOLUNTEER PROGRAM	0			0	0 61.00
62.00	FUNDRAISING	0			0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0 63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0 64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0 65.00
66.00	RESIDENTIAL CARE	0			0	0 66.00
67.00	ADVERTISING	0			0	0 67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0 68.00
69.00	THRIFT STORE	0			0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0 71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0 99.00
100.00	TOTAL	0	0	0	340	430 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2019

Part I
Date/Time Prepared:
5/21/2020 10:03 am

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	18,405					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	18,097	0	0		229,055	51.00
52.00	120	0	0	0	16,063	52.00
53.00	188	0	0	0	25,135	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	18,405	0	0	0	270,253	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069
Hospice CCN: 15-1535

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	744					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	69,109			3.00
4.00	ADMINISTRATIVE & GENERAL	744	0	46,557	-170,843	99,410	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	14,285	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	125	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	107	0	158	13.00
14.00	PHARMACY	0	0	0	0	6,770	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			22,070	0	77,321	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	145	0	291	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	230	0	460	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1,674	0	32,789		170,843	100.00
101.00	UNIT COST MULTIPLIER	2.250000	0.000000	0.474453		1.718570	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2019

Part II
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	100					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPI TE CARE	39	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	61	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	38,835	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	388.350000	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2019

Part II
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			11,855			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	107		13.00
14.00	PHARMACY			0	0	6,770	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	11,657	105	6,657	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	77	1	44	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	121	1	69	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	340	430	18,405	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.028680	4.018692	2.718612	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2019

Part II
Date/Time Prepared:
5/21/2020 10:03 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0			100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-7

Hospice CCN: 15-1535

To 12/31/2019

Date/Time Prepared: 5/21/2020 10:03 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)				
				HCHC	HRHC	HIRC		
				0	1.00	2.00		3.00
ANCILLARY SERVICE COST CENTERS								
1.00	PHYSICAL THERAPY	66.00	0.311051	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	67.00	0.341145	0	0	0	2.00	
3.00	SPEECH PATHOLOGY	68.00	0.323829	0	0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.190464	0	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00	
6.00	LABORATORY	60.00	0.143766	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.364388	0	0	0	7.00	
7.01	IV SOLUTIONS	71.01	0.098315	0	0	0	7.01	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00	
9.00	RADIOLOGY - THERAPEUTIC	55.00	0.000000	0	0	0	9.00	
9.01	ONCOLOGY	55.01	0.488417	0	0	0	9.01	
10.00	CARDIOLOGY	76.00	0.119039	0	0	0	10.00	
10.97	CARDIAC REHABILITATION	76.97	0.249258	0	0	0	10.97	
11.00	Totals (sum of lines 1-11)						11.00	
Cost Center Descriptions		Charges by LOC (from Provider Records)		Shared Service Costs by LOC				
		HGIP		HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)		HGIP (col. 1 x col. 5)
		5.00		6.00	7.00	8.00		9.00
ANCILLARY SERVICE COST CENTERS								
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00	
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00	
6.00	LABORATORY	0	0	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00	
7.01	IV SOLUTIONS	0	0	0	0	0	7.01	
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00	
9.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	9.00	
9.01	ONCOLOGY	0	0	0	0	0	9.01	
10.00	CARDIOLOGY	0	0	0	0	0	10.00	
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97	
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00	

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0069

Period: From 01/01/2019

Worksheet 0-8

Hospice CCN: 15-1535

To 12/31/2019

Date/Time Prepared: 5/21/2020 10:03 am

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)			
5.00	Program cost (line 3 times line 4)	0	0	0
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			229,055
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			1,919
8.00	Total average cost per diem (line 6 divided by line 7)			119.36
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,825	5	
10.00	Program cost (line 8 times line 9)	217,832	597	
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			16,063
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			12
13.00	Total average cost per diem (line 11 divided by line 12)			1,338.58
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	12	0	
15.00	Program cost (line 13 times line 14)	16,063	0	
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			25,135
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			19
18.00	Total average cost per diem (line 16 divided by line 17)			1,322.89
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	19	0	
20.00	Program cost (line 18 times line 19)	25,135	0	
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			270,253
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			1,950
23.00	Average cost per diem (line 21 divided by line 22)			138.59

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0069	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 5/21/2020 10:03 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		774,893	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		5,436	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)		29.02	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	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)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		780,329	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