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: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/28/2020 1:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/28/2020 Time: 1:27 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL (15-0037) 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.

[X] 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) RICK EDWARDS
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	113,037	70,815	0	-199,791	1.00
2.00	Subprovider - IPF	0	2,811	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		10,582		0	10.00
200.00	Total	0	115,848	81,397	0	-199,791	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 NORTH STATE STREET	PO Box:			1.00
2.00	City: GREENFIELD	State: IN	Zip Code: 46140-	County: HANCOCK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		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	HANCOCK REGIONAL HOSPITAL	150037	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	HANCOCK REGIONAL GERO PSYCH UNIT	15S037	26900	4	12/01/1996	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HANCOCK REGIONAL HOSPICE	151547	26900		02/02/1996				14.00
15.00	Hospital-Based Health Clinic - RHC	KNIGHTSTOWN RURAL HEALTH	153987	26900		09/22/1998	N	O	N	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)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	127	575	0	0	548	0	24.00
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		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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	Y	40.00

		V	XVIII	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 in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:27 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	Y	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

		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	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:27 pm

				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 Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:27 pm

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	813,499	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N			122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:27 pm

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:27 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 8/28/2020 1:27 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			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	03/05/2019	Y	03/05/2019 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 1:27 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 1:27 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	37	13,505	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)		37	13,505	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		61	22,265	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	7	2,555			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		78				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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,404	107	3,683			1.00
2.00	HMO and other (see instructions)	0	1,096				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)	1,404	107	3,683			7.00
8.00	INTENSIVE CARE UNIT	1,973	19	4,992			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)	3,377	126	8,675	0.00	635.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,683	0	2,458	0.00	16.44	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	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	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	1,142	0.00	16.65	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	297	0	3,244	0.00	4.36	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	673.11	27.00
28.00	Observation Bed Days		0	2,986			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			46			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	28	58			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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,007	34	2,538	1.00
2.00	HMO and other (see instructions)			0	316		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	1,007	34	2,538	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	134	0	227	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	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	0.00					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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II | Date/Time Prepared: 8/28/2020 1:27 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	53,033,815	-159,886	52,873,929	1,394,181.38	37.92	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	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		1,990,147	0	1,990,147	15,601.55	127.56	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		99,355	0	99,355	4,735.34	20.98	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)		9,418,240	173,220	9,591,460	205,158.00	46.75	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		52,294	0	52,294	899.00	58.17	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		176,725	0	176,725	1,655.48	106.75	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
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,402,470	0	8,402,470			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,750,722	0	1,750,722			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		26,155	0	26,155			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		212,010	0	212,010			23.00
24.00	Wage-related costs (RHC/FQHC)		26,155	0	26,155			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II | Date/Time Prepared: 8/28/2020 1:27 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	528,059	0	528,059	12,888.31	40.97	26.00
27.00	Administrative & General	5.00	10,477,716	-235,172	10,242,544	235,030.61	43.58	27.00
28.00	Administrative & General under contract (see inst.)		211,570	0	211,570	1,742.00	121.45	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,109,744	-8,881	1,100,863	34,623.76	31.80	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,646,808	-1,513	1,645,295	94,097.92	17.48	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,471,746	-1,032,726	439,020	23,747.30	18.49	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,030,494	1,030,494	53,708.00	19.19	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,375,427	-17,702	1,357,725	29,405.13	46.17	38.00
39.00	Central Services and Supply	14.00	179,191	0	179,191	7,661.91	23.39	39.00
40.00	Pharmacy	15.00	1,982,590	-46,297	1,936,293	41,391.95	46.78	40.00
41.00	Medical Records & Medical Records Library	16.00	600,136	-11,014	589,122	21,967.49	26.82	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 8/28/2020 1:27 pm

		Worksheet A Line Number	Amount Reported	Reclassification 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)		51,155,883	-159,886	50,995,997	1,375,586.49	37.07	1.00
2.00	Excluded area salaries (see instructions)		9,418,240	173,220	9,591,460	205,158.00	46.75	2.00
3.00	Subtotal salaries (line 1 minus line 2)		41,737,643	-333,106	41,404,537	1,170,428.49	35.38	3.00
4.00	Subtotal other wages & related costs (see inst.)		229,019	0	229,019	2,554.48	89.65	4.00
5.00	Subtotal wage-related costs (see inst.)		8,402,470	0	8,402,470	0.00	20.29	5.00
6.00	Total (sum of lines 3 thru 5)		50,369,132	-333,106	50,036,026	1,172,982.97	42.66	6.00
7.00	Total overhead cost (see instructions)		19,582,987	-322,811	19,260,176	556,264.38	34.62	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part IV Date/Time Prepared: 8/28/2020 1:27 pm

		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)	2,330,252	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)	3,751,267	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	468,999	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-96,300	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)	301,528	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-73,622	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	3,572,475	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	31,630	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	39,713	22.00
23.00	Tuition Reimbursement	105,128	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,431,070	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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part V Date/Time Prepared: 8/28/2020 1:27 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	52,294	10,431,070	1.00
2.00	Hospital	52,294	10,431,070	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 8/28/2020 1:27 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	224 WEST MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KNIGHTSTOWN	IN	46148	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	137632	07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0037
Component CCN: 15-3987

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

Worksheet S-8
Date/Time Prepared:
8/28/2020 1:27 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	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	3,090	0	0	3,090	11.00
12.00	Hospice Inpatient Respite Care	142	0	0	142	12.00
13.00	Hospice General Inpatient Care	194	0	0	194	13.00
14.00	Total Hospice Days	3,426	0	0	3,426	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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 8/28/2020 1:27 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.247842	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,358,999	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	37,518,958	6.00
7.00	Medicaid cost (line 1 times line 6)	9,298,774	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)	7,939,775	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)	7,939,775	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)	5,950,461	3,261,957	9,212,418	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,474,774	3,261,957	4,736,731	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)	1,474,774	3,261,957	4,736,731	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)	11,959,774	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	163,078	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	250,888	27.01
28.00	Non-Medicare bad debt expense (see instructions)	11,708,886	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,989,764	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	7,726,495	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,666,270	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		11,702,596	11,702,596	0	11,702,596	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	528,059	7,085,768	7,613,827	0	7,613,827	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,477,716	17,433,073	27,910,789	-1,443,932	26,466,857	5.00
7.00	00700	OPERATION OF PLANT	1,109,744	5,253,520	6,363,264	1,431	6,364,695	7.00
9.00	00900	HOUSEKEEPING	1,646,808	838,680	2,485,488	0	2,485,488	9.00
10.00	01000	DIETARY	1,471,746	1,229,725	2,701,471	-1,891,687	809,784	10.00
11.00	01100	CAFETERIA	0	0	0	1,891,687	1,891,687	11.00
13.00	01300	NURSING ADMINISTRATION	1,375,427	392,757	1,768,184	0	1,768,184	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	179,191	71,880	251,071	0	251,071	14.00
15.00	01500	PHARMACY	1,982,590	16,457,959	18,440,549	-15,737,372	2,703,177	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	600,136	310,261	910,397	4,650	915,047	16.00
23.00	02300	PARAMED ED PRGM	83,227	14,345	97,572	0	97,572	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,112,756	912,088	4,024,844	-12,786	4,012,058	30.00
31.00	03100	INTENSIVE CARE UNIT	3,380,314	797,916	4,178,230	-23,791	4,154,439	31.00
40.00	04000	SUBPROVIDER - IPF	1,188,489	243,773	1,432,262	-692	1,431,570	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,460,274	3,940,258	7,400,532	-28,956	7,371,576	50.00
51.00	05100	RECOVERY ROOM	294,667	57,196	351,863	-1,179	350,684	51.00
53.00	05300	ANESTHESIOLOGY	0	165,403	165,403	0	165,403	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,400,130	2,247,977	5,648,107	-216,656	5,431,451	54.00
60.00	06000	LABORATORY	1,676,817	3,080,832	4,757,649	7,832	4,765,481	60.00
65.00	06500	RESPIRATORY THERAPY	1,476,727	275,042	1,751,769	2,589	1,754,358	65.00
66.00	06600	PHYSICAL THERAPY	1,143,934	131,929	1,275,863	-799	1,275,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	328,056	36,978	365,034	0	365,034	67.00
68.00	06800	SPEECH PATHOLOGY	169,616	18,120	187,736	0	187,736	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	644,396	1,025,221	1,669,617	14,818	1,684,435	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,235	3,235	-69	3,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,809,272	2,809,272	0	2,809,272	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,674,291	16,674,291	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	66,814	13,951	80,765	0	80,765	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	257,888	227,153	485,041	-32,161	452,880	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	517,725	268,683	786,408	-13,721	772,687	90.01
90.02	09002	DIABETES CLINIC	39,972	7,308	47,280	0	47,280	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	101,746	87,070	188,816	-25	188,791	90.04
90.05	09005	PRIME TIME	0	91,129	91,129	0	91,129	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	178,708	101,540	280,248	-3,800	276,448	90.06
90.07	04951	ONCOLOGY	1,074,668	1,007,191	2,081,859	-12,317	2,069,542	90.07
90.08	04950	ANDERSON WOMENS CENTER	350,268	82,379	432,647	-378	432,269	90.08
91.00	09100	EMERGENCY	2,568,682	835,957	3,404,639	-26,635	3,378,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,276,486	915,391	2,191,877	-118,738	2,073,139	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,163,777	80,173,556	126,337,333	-968,396	125,368,937	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	238,275	238,275	-13,693	224,582	190.01
190.02	19002	PHYSICIAN BUILDING	0	16,639	16,639	0	16,639	190.02
190.03	19003	PRIVATE DUTY	246,756	628,214	874,970	0	874,970	190.03
190.04	19004	MARKETING	0	0	0	1,443,932	1,443,932	190.04
190.05	19005	SPORTS PHYSICALS	69,949	8,303	78,252	-364	77,888	190.05
190.06	19006	FOUNDATION	197,819	663,025	860,844	0	860,844	190.06
190.07	19007	ASC	0	2,119	2,119	-5	2,114	190.07
190.08	19008	OTHER NONREIMBURSABLE	855,615	17,003	872,618	-12,519	860,099	190.08
190.09	19009	HANCOCK OB	2,320,072	3,231,908	5,551,980	-372,556	5,179,424	190.09
190.10	19010	HANCOCK WELLNESS	790,135	316,118	1,106,253	0	1,106,253	190.10
190.11	19011	MORRISTOWN CLINIC	0	3,000	3,000	0	3,000	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	683,532	336,734	1,020,266	0	1,020,266	190.13
190.14	19014	3 WEST UNIT	198,470	214,187	412,657	-3	412,654	190.14
190.15	19015	NEUROLOGY PHYSICIAN	823,566	338,878	1,162,444	-73,891	1,088,553	190.15
190.16	19016	THORACI	108,978	35,402	144,380	0	144,380	190.16
190.17	19017	HANCOCK ENDO	115,609	76,462	192,071	0	192,071	190.17

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
190.18	19018	HANCOCK FOOT & ANKLE	401,253	219,886	621,139	-2,505	618,634	190.18
190.19	19019	HANCOCK RHEUM	58,284	26,438	84,722	0	84,722	190.19
200.00		TOTAL (SUM OF LINES 118 through 199)	53,033,815	86,546,147	139,579,962	0	139,579,962	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-414,813	11,287,783		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,598,957	5,014,870		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,455,687	18,011,170		5.00
7.00	00700	OPERATION OF PLANT	-23,477	6,341,218		7.00
9.00	00900	HOUSEKEEPING	-159,292	2,326,196		9.00
10.00	01000	DIETARY	-494,857	314,927		10.00
11.00	01100	CAFETERIA	-736,136	1,155,551		11.00
13.00	01300	NURSING ADMINISTRATION	-14,066	1,754,118		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-10,922	240,149		14.00
15.00	01500	PHARMACY	-995,475	1,707,702		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-47,868	867,179		16.00
23.00	02300	PARAMED ED PRGM	-68,831	28,741		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-246,884	3,765,174		30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,154,439		31.00
40.00	04000	SUBPROVIDER - IPF	-96,000	1,335,570		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,308,866	6,062,710		50.00
51.00	05100	RECOVERY ROOM	0	350,684		51.00
53.00	05300	ANESTHESIOLOGY	-134,850	30,553		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-12,868	5,418,583		54.00
60.00	06000	LABORATORY	-313,687	4,451,794		60.00
65.00	06500	RESPIRATORY THERAPY	-59,451	1,694,907		65.00
66.00	06600	PHYSICAL THERAPY	0	1,275,064		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	365,034		67.00
68.00	06800	SPEECH PATHOLOGY	0	187,736		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	-46,940	1,637,495		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,166		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,809,272		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,674,291		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	80,765		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-5,163	447,717		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-7,521	765,166		90.01
90.02	09002	DIABETES CLINIC	-910	46,370		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	-1,125	187,666		90.04
90.05	09005	PRIME TIME	0	91,129		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	-714	275,734		90.06
90.07	04951	ONCOLOGY	-746,472	1,323,070		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	432,269		90.08
91.00	09100	EMERGENCY	-75,225	3,302,779		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	-149	2,072,990		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,077,206	108,291,731		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	224,582		190.01
190.02	19002	PHYSICIAN BUILDING	0	16,639		190.02
190.03	19003	PRIVATE DUTY	0	874,970		190.03
190.04	19004	MARKETING	0	1,443,932		190.04
190.05	19005	SPORTS PHYSICALS	0	77,888		190.05
190.06	19006	FOUNDATION	0	860,844		190.06
190.07	19007	ASC	0	2,114		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	860,099		190.08
190.09	19009	HANCOCK OB	0	5,179,424		190.09
190.10	19010	HANCOCK WELLNESS	0	1,106,253		190.10
190.11	19011	MORRISTOWN CLINIC	0	3,000		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	1,020,266		190.13
190.14	19014	3 WEST UNIT	0	412,654		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,088,553		190.15
190.16	19016	THORACI	0	144,380		190.16
190.17	19017	HANCOCK ENDO	0	192,071		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	618,634		190.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
190.19	19019	HANCOCK RHEUM	0	84,722		190.19
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,077,206	122,502,756		200.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/28/2020 1:27 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	1,030,494	861,193		1.00
	0		1,030,494	861,193		
	B - PLANT					
1.00	OPERATION OF PLANT	7.00	0	1,431		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,650		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	4,574		3.00
4.00	RESPIRATORY THERAPY	65.00	0	3,038		4.00
	0		0	13,693		
	C - MARKETING					
1.00	MARKETING	190.04	175,072	1,268,860		1.00
	0		175,072	1,268,860		
	D - OUTPATIENT PROCEDURE					
1.00	LABORATORY	60.00	6,760	1,846		1.00
2.00	ELECTROCARDIOLOGY	69.00	33,620	9,182		2.00
	0		40,380	11,028		
	E - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,674,291		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
	0		0	16,674,291		
	F - TERM ETO BENEFIT RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60,100		1.00
2.00	OPERATION OF PLANT	7.00	0	8,881		2.00
3.00	HOUSEKEEPING	9.00	0	1,513		3.00
4.00	DIETARY	10.00	0	2,232		4.00
5.00	NURSING ADMINISTRATION	13.00	0	17,702		5.00
6.00	PHARMACY	15.00	0	5,917		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	11,014		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	6,083		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	12,172		9.00
10.00	OPERATING ROOM	50.00	0	1,583		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,324		11.00
12.00	LABORATORY	60.00	0	22		12.00
13.00	RESPIRATORY THERAPY	65.00	0	5,481		13.00
14.00	WOUND CLINIC	90.01	0	11,871		14.00
15.00	SHELBYVILLE WOUND CLINIC	90.06	0	3,218		15.00
16.00	EMERGENCY	91.00	0	2,921		16.00
17.00	HOSPICE	116.00	0	209		17.00
18.00	PRIVATE DUTY	190.03	0	580		18.00
19.00	HANCOCK WELLNESS	190.10	0	804		19.00
20.00	MCCORD WELLNESS	190.13	0	259		20.00
	TOTALS		0	159,886		
500.00	Grand Total: Increases		1,245,946	18,988,951		500.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/28/2020 1:27 pm

		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	1,030,494	861,193	0		1.00
	0		1,030,494	861,193			
	B - PLANT						
1.00	PROFESSIONAL BUILDING	190.01	0	13,693	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	13,693			
	C - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	175,072	1,268,860	0		1.00
	0		175,072	1,268,860			
	D - OUTPATIENT PROCEDURE						
1.00	PHARMACY	15.00	40,380	11,028	0		1.00
2.00		0.00	0	0	0		2.00
	0		40,380	11,028			
	E - DRUG RECLASS						
1.00	PHARMACY	15.00	0	15,685,964	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	12,786	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	23,791	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	692	0		4.00
5.00	OPERATING ROOM	50.00	0	28,956	0		5.00
6.00	RECOVERY ROOM	51.00	0	1,179	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	216,656	0		7.00
8.00	LABORATORY	60.00	0	774	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	449	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	799	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	32,558	0		11.00
12.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	69	0		12.00
13.00	RURAL HEALTH CLINIC	88.00	0	32,161	0		13.00
14.00	WOUND CLINIC	90.01	0	13,721	0		14.00
15.00	ANDIS CLINIC	90.04	0	25	0		15.00
16.00	SHELBYVILLE WOUND CLINIC	90.06	0	3,800	0		16.00
17.00	ONCOLOGY	90.07	0	12,317	0		17.00
18.00	ANDERSON WOMENS CENTER	90.08	0	378	0		18.00
19.00	EMERGENCY	91.00	0	26,635	0		19.00
20.00	HOSPICE	116.00	0	118,738	0		20.00
21.00	SPORTS PHYSICALS	190.05	0	364	0		21.00
22.00	ASC	190.07	0	5	0		22.00
23.00	OTHER NONREIMBURSABLE	190.08	0	12,519	0		23.00
24.00	HANCOCK OB	190.09	0	372,556	0		24.00
25.00	3 WEST UNIT	190.14	0	3	0		25.00
26.00	HANCOCK FOOT & ANKLE	190.18	0	2,505	0		26.00
27.00	NEUROLOGY PHYSICIAN	190.15	0	73,891	0		27.00
	0		0	16,674,291			
	F - TERM ETO BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	60,100	0	0		1.00
2.00	OPERATION OF PLANT	7.00	8,881	0	0		2.00
3.00	HOUSEKEEPING	9.00	1,513	0	0		3.00
4.00	DIETARY	10.00	2,232	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	17,702	0	0		5.00
6.00	PHARMACY	15.00	5,917	0	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	11,014	0	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	6,083	0	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	12,172	0	0		9.00
10.00	OPERATING ROOM	50.00	1,583	0	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	7,324	0	0		11.00
12.00	LABORATORY	60.00	22	0	0		12.00
13.00	RESPIRATORY THERAPY	65.00	5,481	0	0		13.00
14.00	WOUND CLINIC	90.01	11,871	0	0		14.00
15.00	SHELBYVILLE WOUND CLINIC	90.06	3,218	0	0		15.00
16.00	EMERGENCY	91.00	2,921	0	0		16.00
17.00	HOSPICE	116.00	209	0	0		17.00
18.00	PRIVATE DUTY	190.03	580	0	0		18.00
19.00	HANCOCK WELLNESS	190.10	804	0	0		19.00
20.00	MCCORD WELLNESS	190.13	259	0	0		20.00
	TOTALS		159,886	0			
500.00	Grand Total: Decreases		1,405,832	18,829,065			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,022,435	0	0	0	0	1.00
2.00	Land Improvements	7,498,607	7,112,108	0	7,112,108	0	2.00
3.00	Buildings and Fixtures	117,785,819	12,930,599	0	12,930,599	0	3.00
4.00	Building Improvements	235,570	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	79,660,653	6,763,753	0	6,763,753	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	206,203,084	26,806,460	0	26,806,460	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	206,203,084	26,806,460	0	26,806,460	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,022,435	0	1.00
2.00	Land Improvements	14,610,715	0	2.00
3.00	Buildings and Fixtures	130,716,418	0	3.00
4.00	Building Improvements	235,570	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	86,424,406	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	233,009,544	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	233,009,544	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 8/28/2020 1:27 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,465,716	0	399	776,355	460,126	1.00
3.00	Total (sum of lines 1-2)	10,465,716	0	399	776,355	460,126	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	11,702,596		1.00
3.00	Total (sum of lines 1-2)	0	11,702,596		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III | Date/Time Prepared: 8/28/2020 1:27 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	130,716,418	0	130,716,418	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	130,716,418	0	130,716,418	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	10,465,716	-412,552	1.00
3.00	Total (sum of lines 1-2)	0	0	0	10,465,716	-412,552	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	-1,862	776,355	460,126	0	11,287,783	1.00
3.00	Total (sum of lines 1-2)	-1,862	776,355	460,126	0	11,287,783	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/28/2020 1:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,200,994			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-736,136	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/28/2020 1:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	HRH MMO RENTAL INCOME	B	-160,308	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
33.01	HRH HUMAN RESOURCES MISCELLANEOUS RE	B	-149,546	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	HRH OTHER REVENUE SALES TAX	B	-8,496	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	HRH OTHER REVENUE MISCELLANEOUS REVE	B	-1,393	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HRH MED STAFF SERV QA APPLICATION FE	B	-18,600	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HRH MED STAFF SERV MISCELLANEOUS REV	B	-6,384	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-41,100	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-2,469	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	HRH INFO SERVICES MISCELLANEOUS REVE	B	-54,550	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-15,950	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	HRH ACCOUNTING MANAGEMENT FEES	B	-8,486	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-25,016	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH COMMUNICATIONS MISCELLANEOUS REV	B	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH COMMUNICATIONS PHONE LEASE REVEN	B	-157,406	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH COMM EDUCATION EDUCATION SERVICE	B	-8,168	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH HEALTHY 365 MISCELLANEOUS REVENU	B	-415	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	7,263	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH PLANT OFFSITE SERVICES	B	-18,841	OPERATION OF PLANT	7.00	0	33.17
33.18	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B	-159,292	HOUSEKEEPING	9.00	0	33.18
33.19	HRH NUTRITIONAL SER LTACH REVENUE	B	-77,197	DIETARY	10.00	0	33.19
33.20	HRH NUTRITIONAL SER MISCELLANEOUS RE	B	-200	DIETARY	10.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-4,049	DIETARY	10.00	0	33.22
33.23	HRH CLINICAL EDUCAT AHA COURSE REVEN	B	-14,066	NURSING ADMINISTRATION	13.00	0	33.23
33.24	HRH OTHER REVENUE REBATES/REFUNDS	B	-6,561	CENTRAL SERVICES & SUPPLY	14.00	0	33.24
33.25	HRH OTHER REVENUE DISCOUNTS EARNED O	B	-4,361	CENTRAL SERVICES & SUPPLY	14.00	0	33.25
33.26	HRH PHARMACY MISCELLANEOUS REVENUE	B	-2,495	PHARMACY	15.00	0	33.26
33.27	HRH PHARMACY REBATES/REFUNDS	B	-19,444	PHARMACY	15.00	0	33.27
33.28	HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-784,982	PHARMACY	15.00	0	33.28
33.29	HRH ASSOCIATE PHARM HOSPICE PHARMACY	B	-152,079	PHARMACY	15.00	0	33.29
33.30	HRH ASSOCIATE PHARM PHARMACY MEDS TO	B	-8,416	PHARMACY	15.00	0	33.30
33.31	HRH ASSOCIATE PHARM MISCELLANEOUS RE	B	-28,059	PHARMACY	15.00	0	33.31
33.32	HRH HEALTH INFO SER MEDICAL RECORDS-	B	-341	MEDICAL RECORDS & LIBRARY	16.00	0	33.32

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/28/2020 1:27 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.33	HRH HEALTH INFO SER MISCELLANEOUS RE	B	-47,527	MEDICAL RECORDS & LIBRARY	16.00	0	33.33
33.34	HRH X-RAY SCHOOL TUITION-X-RAY SCHOO	B	-68,831	PARAMED ED PRGM	23.00	0	33.34
33.35	HRH MED/SURG-3 WEST MISCELLANEOUS RE	B	-133,034	ADULTS & PEDIATRICS	30.00	0	33.35
33.36	HRH ANDIS UNIT REBATES/REFUNDS	B	-663	ADULTS & PEDIATRICS	30.00	0	33.36
33.37	HRH SURGERY REBATES/REFUNDS	B	-4,199	OPERATING ROOM	50.00	0	33.37
33.38	HRH LAB WATER TESTING	B	-75,215	LABORATORY	60.00	0	33.38
33.39	HRH LAB DIRECT TESTS	B	-59,245	LABORATORY	60.00	0	33.39
33.40	HRH LAB MISCELLANEOUS REVENUE	B	-92,697	LABORATORY	60.00	0	33.40
33.41	HRH WATER LAB WATER TESTING	B	13	LABORATORY	60.00	0	33.41
33.42	HRH SLEEP STUDY CLINIC MANAGMENT	B	-58,169	RESPIRATORY THERAPY	65.00	0	33.42
33.43	HRH SLEEP STUDY SLEEP STUDY FEES	B	-1,282	RESPIRATORY THERAPY	65.00	0	33.43
33.44	HRH CATH LAB REBATES/REFUNDS	B	-46,940	ELECTROCARDIOLOGY	69.00	0	33.44
33.45	HRH MED ONCOLOGY MISCELLANEOUS REVEN	B	-60,606	ONCOLOGY	90.07	0	33.45
33.46	HRH E R REBATES/REFUNDS	B	-225	EMERGENCY	91.00	0	33.46
33.47	MOW	A	-413,411	DIETARY	10.00	0	33.47
33.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.48
33.49	PHYSICIAN RECRUITMENT FEES	A	-33,750	ADMINISTRATIVE & GENERAL	5.00	0	33.49
33.50	DONATIONS & SPONSORSHIPS	A	-272,681	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	ADVERTISING FEE	A	-114,894	ADMINISTRATIVE & GENERAL	5.00	0	33.51
33.52	ADVERTISING FEE	A	-635,174	ADMINISTRATIVE & GENERAL	5.00	0	33.52
33.53	ADVERTISING FEE	A	-2,428	ADULTS & PEDIATRICS	30.00	0	33.53
33.54	ADVERTISING FEE	A	-100	OPERATING ROOM	50.00	0	33.54
33.55	ADVERTISING FEE	A	-1,511	RADIOLOGY-DIAGNOSTIC	54.00	0	33.55
33.56	ADVERTISING FEE	A	-1,896	WOUND CLINIC	90.01	0	33.56
33.57	ADVERTISING FEE	A	-714	SHELBYVILLE WOUND CLINIC	90.06	0	33.57
33.58	IHA LOBBYING EXPENSE	A	-2,596	ADMINISTRATIVE & GENERAL	5.00	0	33.58
33.59	AHA LOBBYING EXPENSE	A	-5,873	ADMINISTRATIVE & GENERAL	5.00	0	33.59
33.60	PHY OFFICE BLDG	A	-167,206	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.60
33.61	PHY OFFICE BLDG	A	-11,357	RADIOLOGY-DIAGNOSTIC	54.00	0	33.61
33.62	PHY OFFICE BLDG	A	-5,163	RURAL HEALTH CLINIC	88.00	0	33.62
33.63	INTEREST REVENUE	B	-2,261	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.63
33.64	RENTAL PROPERTIES EXPENSE	A	-85,038	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.64
33.65	RENTAL PROPERTIES EXPENSE	A	-208,330	ADMINISTRATIVE & GENERAL	5.00	0	33.65
33.66	RENTAL PROPERTIES EXPENSE	A	-4,636	OPERATION OF PLANT	7.00	0	33.66
33.67	TELEPHONE SERVICES	A	-50,774	ADMINISTRATIVE & GENERAL	5.00	0	33.67
33.68	HAF EXPENSE	A	-6,090,496	ADMINISTRATIVE & GENERAL	5.00	0	33.68
33.69	HRH HOSPICE MISCELLANEOUS REVENUE	B	-149	HOSPICE	116.00	0	33.69
33.70	SELF INSURANCE CLAIM EXPENSE	A	-2,449,411	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.70
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,077,206				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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 8/28/2020 1:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	328,990	328,990	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	14,217	14,217	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	190,135	190,135	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	5,625	5,625	0	0	0	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	12,097	12,097	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	15,000	15,000	0	0	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	133,685	133,685	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	110,759	110,759	0	0	0	8.00
9.00	40.00	SUBPROVIDER - IPF	96,000	96,000	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	50.00	OPERATING ROOM	1,298,272	1,298,272	0	0	0	11.00
12.00	50.00	OPERATING ROOM	6,295	6,295	0	0	0	12.00
13.00	53.00	ANESTHESIOLOGY	134,850	134,850	0	0	0	13.00
14.00	60.00	LABORATORY	114,583	86,543	28,040	260,300	486	14.00
15.00	90.01	WOUND CLINIC	5,625	5,625	0	0	0	15.00
16.00	90.02	DIABETES CLINIC	910	910	0	0	0	16.00
17.00	90.04	ANDIS CLINIC	1,125	1,125	0	0	0	17.00
18.00	90.07	ONCOLOGY	685,866	685,866	0	0	0	18.00
19.00	91.00	EMERGENCY	75,000	75,000	0	0	0	19.00
200.00			3,229,034	3,200,994	28,040		486	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	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	8.00
9.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	50.00	OPERATING ROOM	0	0	0	0	0	11.00
12.00	50.00	OPERATING ROOM	0	0	0	0	0	12.00
13.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	60,820	3,041	0	0	0	14.00
15.00	90.01	WOUND CLINIC	0	0	0	0	0	15.00
16.00	90.02	DIABETES CLINIC	0	0	0	0	0	16.00
17.00	90.04	ANDIS CLINIC	0	0	0	0	0	17.00
18.00	90.07	ONCOLOGY	0	0	0	0	0	18.00
19.00	91.00	EMERGENCY	0	0	0	0	0	19.00
200.00			60,820	3,041	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	0	0	328,990		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	14,217		2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	190,135		3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	5,625		4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	12,097		5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	15,000		6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	133,685		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	110,759		8.00
9.00	40.00	SUBPROVIDER - IPF	0	0	0	96,000		9.00
10.00	0.00		0	0	0	0		10.00
11.00	50.00	OPERATING ROOM	0	0	0	1,298,272		11.00
12.00	50.00	OPERATING ROOM	0	0	0	6,295		12.00
13.00	53.00	ANESTHESIOLOGY	0	0	0	134,850		13.00
14.00	60.00	LABORATORY	0	60,820	0	86,543		14.00
15.00	90.01	WOUND CLINIC	0	0	0	5,625		15.00
16.00	90.02	DIABETES CLINIC	0	0	0	910		16.00
17.00	90.04	ANDIS CLINIC	0	0	0	1,125		17.00
18.00	90.07	ONCOLOGY	0	0	0	685,866		18.00
19.00	91.00	EMERGENCY	0	0	0	75,000		19.00
200.00			0	60,820	0	3,200,994		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	11,287,783	11,287,783				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,014,870	80,485	5,095,355			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,011,170	848,863	997,016	19,857,049	19,857,049	5.00
7.00	00700	OPERATION OF PLANT	6,341,218	570,489	107,158	7,018,865	1,357,813	7.00
9.00	00900	HOUSEKEEPING	2,326,196	70,886	160,153	2,557,235	494,702	9.00
10.00	01000	DIETARY	314,927	372,022	42,734	729,683	141,159	10.00
11.00	01100	CAFETERIA	1,155,551	0	100,308	1,255,859	242,948	11.00
13.00	01300	NURSING ADMINISTRATION	1,754,118	0	132,161	1,886,279	364,904	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	240,149	0	17,442	257,591	49,831	14.00
15.00	01500	PHARMACY	1,707,702	192,046	188,479	2,088,227	403,972	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	867,179	127,581	57,345	1,052,105	203,532	16.00
23.00	02300	PARAMED ED PRGM	28,741	43,148	8,101	79,990	15,474	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,765,174	730,656	302,404	4,798,234	928,228	30.00
31.00	03100	INTENSIVE CARE UNIT	4,154,439	765,682	327,855	5,247,976	1,015,231	31.00
40.00	04000	SUBPROVIDER - IPF	1,335,570	204,695	115,688	1,655,953	320,347	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,062,710	807,385	336,669	7,206,764	1,394,163	50.00
51.00	05100	RECOVERY ROOM	350,684	68,061	28,683	447,428	86,556	51.00
53.00	05300	ANESTHESIOLOGY	30,553	0	0	30,553	5,911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,418,583	834,513	330,256	6,583,352	1,273,563	54.00
60.00	06000	LABORATORY	4,451,794	187,616	163,877	4,803,287	929,205	60.00
65.00	06500	RESPIRATORY THERAPY	1,694,907	75,573	143,211	1,913,691	370,207	65.00
66.00	06600	PHYSICAL THERAPY	1,275,064	124,853	111,351	1,511,268	292,358	66.00
67.00	06700	OCCUPATIONAL THERAPY	365,034	0	31,933	396,967	76,794	67.00
68.00	06800	SPEECH PATHOLOGY	187,736	0	16,510	204,246	39,512	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,637,495	240,556	65,998	1,944,049	376,080	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,166	150,632	0	153,798	29,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,809,272	0	0	2,809,272	543,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,674,291	0	0	16,674,291	3,225,709	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	80,765	73,165	6,504	160,434	31,036	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	447,717	0	25,103	472,820	91,468	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	765,166	93,134	49,240	907,540	175,565	90.01
90.02	09002	DIABETES CLINIC	46,370	0	3,891	50,261	9,723	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	187,666	83,599	9,904	281,169	54,393	90.04
90.05	09005	PRIME TIME	91,129	0	0	91,129	17,629	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	275,734	0	17,082	292,816	56,646	90.06
90.07	04951	ONCOLOGY	1,323,070	446,022	104,608	1,873,700	362,471	90.07
90.08	04950	ANDERSON WOMENS CENTER	432,269	0	34,095	466,364	90,219	90.08
91.00	09100	EMERGENCY	3,302,779	709,660	249,751	4,262,190	824,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,072,990	347,687	124,233	2,544,910	492,318	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,291,731	8,249,009	4,409,743	104,567,345	16,387,408	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	224,582	2,350,303	0	2,574,885	498,117	190.01
190.02	19002	PHYSICIAN BUILDING	16,639	0	0	16,639	3,219	190.02
190.03	19003	PRIVATE DUTY	874,970	0	23,963	898,933	173,900	190.03
190.04	19004	MARKETING	1,443,932	0	17,042	1,460,974	282,628	190.04
190.05	19005	SPORTS PHYSICALS	77,888	0	6,809	84,697	16,385	190.05
190.06	19006	FOUNDATION	860,844	77,371	19,256	957,471	185,225	190.06
190.07	19007	ASC	2,114	0	0	2,114	409	190.07
190.08	19008	OTHER NONREIMBURSABLE	860,099	0	83,286	943,385	182,500	190.08
190.09	19009	HANCOCK OB	5,179,424	208,002	225,836	5,613,262	1,085,897	190.09
190.10	19010	HANCOCK WELLNESS	1,106,253	0	76,833	1,183,086	228,870	190.10
190.11	19011	MORRISTOWN CLINIC	3,000	0	0	3,000	580	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	1,020,266	0	66,510	1,086,776	210,239	190.13
190.14	19014	3 WEST UNIT	412,654	403,098	19,319	835,071	161,546	190.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
190.15	19015	NEUROLOGY PHYSICIAN	1,088,553	0	80,166	1,168,719	226,091	190.15
190.16	19016	THORACI	144,380	0	10,608	154,988	29,983	190.16
190.17	19017	HANCOCK ENDO	192,071	0	11,253	203,324	39,333	190.17
190.18	19018	HANCOCK FOOT & ANKLE	618,634	0	39,058	657,692	127,232	190.18
190.19	19019	HANCOCK RHEUM	84,722	0	5,673	90,395	17,487	190.19
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	122,502,756	11,287,783	5,095,355	122,502,756	19,857,049	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	8,376,678					7.00
9.00	00900	HOUSEKEEPING	109,164	3,161,101				9.00
10.00	01000	DIETARY	572,911	0	1,443,753			10.00
11.00	01100	CAFETERIA	0	52,514	0	1,551,321		11.00
13.00	01300	NURSING ADMINISTRATION	0	86,536	0	53,115	2,390,834	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	131,264	0	13,748	26,187	14.00
15.00	01500	PHARMACY	295,750	95,750	0	74,790	142,462	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	196,475	115,172	0	40,063	76,313	16.00
23.00	02300	PARAMED ED PRGM	66,447	132,669	0	3,589	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,125,206	880,206	740,151	143,356	273,068	30.00
31.00	03100	INTENSIVE CARE UNIT	1,179,146	181,467	0	176,043	335,329	31.00
40.00	04000	SUBPROVIDER - IPF	315,230	145,230	480,404	61,355	116,869	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	352,339	0	96,833	184,450	50.00
51.00	05100	RECOVERY ROOM	104,813	129,739	0	11,955	22,773	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	128,977	0	170,477	324,729	54.00
60.00	06000	LABORATORY	0	123,078	0	109,164	207,938	60.00
65.00	06500	RESPIRATORY THERAPY	0	94,265	0	77,650	147,910	65.00
66.00	06600	PHYSICAL THERAPY	192,272	109,554	0	51,847	98,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	16,866	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,122	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	370,454	213,611	0	28,974	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	231,973	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	112,674	0	0	5,055	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	27,950	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	2,318	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	128,742	0	0	5,112	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	8,200	0	90.06
90.07	04951	ONCOLOGY	686,871	0	0	57,762	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	188,730	0	20,172	0	90.08
91.00	09100	EMERGENCY	1,092,872	0	0	125,350	238,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	535,436	0	223,198	62,139	118,363	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,316,436	3,161,101	1,443,753	1,451,005	2,313,919	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	40,379	76,915	190.03
190.04	19004	MARKETING	0	0	0	8,464	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	119,151	0	0	10,970	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	320,322	0	0	25,108	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	620,769	0	0	8,245	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	7,150	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
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)	8,376,678	3,161,101	1,443,753	1,551,321	2,390,834	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	478,621					14.00
15.00	01500	PHARMACY	15,492	3,116,443				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,683,660			16.00
23.00	02300	PARAMED ED PRGM	1	0	0	298,170		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,780	0	453,848	0	9,365,077	30.00
31.00	03100	INTENSIVE CARE UNIT	26,105	0	56,669	0	8,217,966	31.00
40.00	04000	SUBPROVIDER - IPF	2,166	0	46,727	0	3,144,281	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	137,721	0	596,513	0	9,968,783	50.00
51.00	05100	RECOVERY ROOM	2,080	0	0	0	805,344	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	36,464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,988	0	68,102	298,170	8,864,358	54.00
60.00	06000	LABORATORY	122,930	0	151,117	0	6,446,719	60.00
65.00	06500	RESPIRATORY THERAPY	5,427	0	0	0	2,609,150	65.00
66.00	06600	PHYSICAL THERAPY	1,357	0	0	0	2,257,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	763	0	0	0	491,390	67.00
68.00	06800	SPEECH PATHOLOGY	287	0	0	0	251,167	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	59,361	0	0	0	2,992,529	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	77,547	0	493,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,352,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,116,443	0	0	23,016,443	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	83	0	0	0	309,282	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,619	0	0	0	565,907	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	5,733	0	0	0	1,116,788	90.01
90.02	09002	DIABETES CLINIC	81	0	0	0	62,383	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	60	0	0	0	469,476	90.04
90.05	09005	PRIME TIME	0	0	0	0	108,758	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	1,328	0	0	0	358,990	90.06
90.07	04951	ONCOLOGY	6,257	0	0	0	2,987,061	90.07
90.08	04950	ANDERSON WOMENS CENTER	3,301	0	0	0	768,786	90.08
91.00	09100	EMERGENCY	34,362	0	233,137	0	6,811,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	6,158	0	0	0	3,982,522	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	472,440	3,116,443	1,683,660	298,170	99,854,050	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	3,073,002	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	19,858	190.02
190.03	19003	PRIVATE DUTY	311	0	0	0	1,190,438	190.03
190.04	19004	MARKETING	0	0	0	0	1,752,066	190.04
190.05	19005	SPORTS PHYSICALS	5	0	0	0	101,087	190.05
190.06	19006	FOUNDATION	0	0	0	0	1,272,817	190.06
190.07	19007	ASC	11	0	0	0	2,534	190.07
190.08	19008	OTHER NONREIMBURSABLE	506	0	0	0	1,126,391	190.08
190.09	19009	HANCOCK OB	3,803	0	0	0	7,048,392	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	1,411,956	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	3,580	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	1,297,015	190.13
190.14	19014	3 WEST UNIT	175	0	0	0	1,625,806	190.14
190.15	19015	NEUROLOGY PHYSICIAN	200	0	0	0	1,402,160	190.15
190.16	19016	THORACI	0	0	0	0	184,971	190.16
190.17	19017	HANCOCK ENDO	63	0	0	0	242,720	190.17
190.18	19018	HANCOCK FOOT & ANKLE	1,107	0	0	0	786,031	190.18

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
190.19	19019	HANCOCK RHEUM	0	0	0	0	107,882	190.19
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	478,621	3,116,443	1,683,660	298,170	122,502,756	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	9,365,077		30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,217,966		31.00
40.00	04000	SUBPROVIDER - IPF	0	3,144,281		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	9,968,783		50.00
51.00	05100	RECOVERY ROOM	0	805,344		51.00
53.00	05300	ANESTHESIOLOGY	0	36,464		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,864,358		54.00
60.00	06000	LABORATORY	0	6,446,719		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,609,150		65.00
66.00	06600	PHYSICAL THERAPY	0	2,257,414		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	491,390		67.00
68.00	06800	SPEECH PATHOLOGY	0	251,167		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	2,992,529		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	493,071		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,352,731		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,016,443		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	309,282		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	565,907		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,116,788		90.01
90.02	09002	DIABETES CLINIC	0	62,383		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	469,476		90.04
90.05	09005	PRIME TIME	0	108,758		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	358,990		90.06
90.07	04951	ONCOLOGY	0	2,987,061		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	768,786		90.08
91.00	09100	EMERGENCY	0	6,811,210		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	3,982,522		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	99,854,050		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	3,073,002		190.01
190.02	19002	PHYSICIAN BUILDING	0	19,858		190.02
190.03	19003	PRIVATE DUTY	0	1,190,438		190.03
190.04	19004	MARKETING	0	1,752,066		190.04
190.05	19005	SPORTS PHYSICALS	0	101,087		190.05
190.06	19006	FOUNDATION	0	1,272,817		190.06
190.07	19007	ASC	0	2,534		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	1,126,391		190.08
190.09	19009	HANCOCK OB	0	7,048,392		190.09
190.10	19010	HANCOCK WELLNESS	0	1,411,956		190.10
190.11	19011	MORRISTOWN CLINIC	0	3,580		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	1,297,015		190.13
190.14	19014	3 WEST UNIT	0	1,625,806		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,402,160		190.15
190.16	19016	THORACI	0	184,971		190.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
190.17	19017	HANCOCK ENDO	0	242,720		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	786,031		190.18
190.19	19019	HANCOCK RHEUM	0	107,882		190.19
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	122,502,756		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	80,485	80,485	80,485		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	848,863	848,863	15,730	864,593	5.00
7.00	00700	OPERATION OF PLANT	0	570,489	570,489	1,693	59,120	7.00
9.00	00900	HOUSEKEEPING	0	70,886	70,886	2,530	21,540	9.00
10.00	01000	DIETARY	0	372,022	372,022	675	6,146	10.00
11.00	01100	CAFETERIA	0	0	0	1,585	10,578	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,088	15,888	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	276	2,170	14.00
15.00	01500	PHARMACY	0	192,046	192,046	2,978	17,589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	127,581	127,581	906	8,862	16.00
23.00	02300	PARAMED ED PRGM	0	43,148	43,148	128	674	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	730,656	730,656	4,778	40,416	30.00
31.00	03100	INTENSIVE CARE UNIT	0	765,682	765,682	5,180	44,204	31.00
40.00	04000	SUBPROVIDER - IPF	0	204,695	204,695	1,828	13,948	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	807,385	807,385	5,319	60,703	50.00
51.00	05100	RECOVERY ROOM	0	68,061	68,061	453	3,769	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	834,513	834,513	5,218	55,452	54.00
60.00	06000	LABORATORY	0	187,616	187,616	2,589	40,458	60.00
65.00	06500	RESPIRATORY THERAPY	0	75,573	75,573	2,263	16,119	65.00
66.00	06600	PHYSICAL THERAPY	0	124,853	124,853	1,759	12,729	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	505	3,344	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	261	1,720	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	240,556	240,556	1,043	16,375	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	150,632	150,632	0	1,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	23,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	140,456	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	73,165	73,165	103	1,351	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	397	3,983	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	93,134	93,134	778	7,644	90.01
90.02	09002	DIABETES CLINIC	0	0	0	61	423	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	83,599	83,599	156	2,368	90.04
90.05	09005	PRIME TIME	0	0	0	0	768	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	270	2,466	90.06
90.07	04951	ONCOLOGY	0	446,022	446,022	1,653	15,782	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	539	3,928	90.08
91.00	09100	EMERGENCY	0	709,660	709,660	3,946	35,900	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	347,687	347,687	1,963	21,436	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,249,009	8,249,009	69,651	713,523	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	2,350,303	2,350,303	0	21,688	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	140	190.02
190.03	19003	PRIVATE DUTY	0	0	0	379	7,572	190.03
190.04	19004	MARKETING	0	0	0	269	12,306	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	108	713	190.05
190.06	19006	FOUNDATION	0	77,371	77,371	304	8,065	190.06
190.07	19007	ASC	0	0	0	0	18	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	1,316	7,946	190.08
190.09	19009	HANCOCK OB	0	208,002	208,002	3,568	47,281	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	1,214	9,965	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	25	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	1,051	9,154	190.13
190.14	19014	3 WEST UNIT	0	403,098	403,098	305	7,034	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	1,267	9,844	190.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
190.16	19016	THORACI	0	0	0	168	1,305	190.16
190.17	19017	HANCOCK ENDO	0	0	0	178	1,713	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	617	5,540	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	90	761	190.19
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	11,287,783	11,287,783	80,485	864,593	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	631,302					7.00
9.00	00900	HOUSEKEEPING	8,227	103,183				9.00
10.00	01000	DIETARY	43,177	0	422,020			10.00
11.00	01100	CAFETERIA	0	1,714	0	13,877		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,825	0	475	21,276	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,285	0	123	233	14.00
15.00	01500	PHARMACY	22,289	3,125	0	669	1,268	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,807	3,759	0	358	679	16.00
23.00	02300	PARAMED ED PRGM	5,008	4,331	0	32	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,800	28,731	216,351	1,282	2,430	30.00
31.00	03100	INTENSIVE CARE UNIT	88,866	5,923	0	1,574	2,985	31.00
40.00	04000	SUBPROVIDER - IPF	23,757	4,741	140,426	549	1,040	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,501	0	866	1,641	50.00
51.00	05100	RECOVERY ROOM	7,899	4,235	0	107	203	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,210	0	1,525	2,890	54.00
60.00	06000	LABORATORY	0	4,017	0	977	1,850	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,077	0	695	1,316	65.00
66.00	06600	PHYSICAL THERAPY	14,490	3,576	0	464	879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	151	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	64	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	27,919	6,973	0	259	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,482	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	8,492	0	0	45	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	250	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	21	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	9,703	0	0	46	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	73	0	90.06
90.07	04951	ONCOLOGY	51,765	0	0	517	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	6,160	0	180	0	90.08
91.00	09100	EMERGENCY	82,363	0	0	1,121	2,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	40,353	0	65,243	556	1,053	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	551,397	103,183	422,020	12,979	20,592	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	361	684	190.03
190.04	19004	MARKETING	0	0	0	76	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	8,980	0	0	98	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	24,141	0	0	225	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	46,784	0	0	74	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	64	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
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)	631,302	103,183	422,020	13,877	21,276	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	7,087					14.00
15.00	01500	PHARMACY	229	240,193				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	156,952			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	53,321		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	337	0	42,308		1,152,089	30.00
31.00	03100	INTENSIVE CARE UNIT	387	0	5,283		920,084	31.00
40.00	04000	SUBPROVIDER - IPF	32	0	4,356		395,372	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,039	0	55,607		945,061	50.00
51.00	05100	RECOVERY ROOM	31	0	0		84,758	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	252	0	6,349		910,409	54.00
60.00	06000	LABORATORY	1,821	0	14,087		253,415	60.00
65.00	06500	RESPIRATORY THERAPY	80	0	0		99,123	65.00
66.00	06600	PHYSICAL THERAPY	20	0	0		158,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	11	0	0		4,011	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	0		2,049	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		0	68.01
69.00	06900	ELECTROCARDIOLOGY	879	0	0		294,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	7,229		176,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		23,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	240,193	0		380,649	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	1	0	0		83,157	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24	0	0		4,404	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	85	0	0		101,891	90.01
90.02	09002	DIABETES CLINIC	1	0	0		506	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	1	0	0		95,873	90.04
90.05	09005	PRIME TIME	0	0	0		768	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	20	0	0		2,829	90.06
90.07	04951	ONCOLOGY	93	0	0		515,832	90.07
90.08	04950	ANDERSON WOMENS CENTER	49	0	0		10,856	90.08
91.00	09100	EMERGENCY	509	0	21,733		857,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	91	0	0		478,382	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,996	240,193	156,952	0	7,952,206	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		2,371,991	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		140	190.02
190.03	19003	PRIVATE DUTY	5	0	0		9,001	190.03
190.04	19004	MARKETING	0	0	0		12,651	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		821	190.05
190.06	19006	FOUNDATION	0	0	0		94,818	190.06
190.07	19007	ASC	0	0	0		18	190.07
190.08	19008	OTHER NONREIMBURSABLE	7	0	0		9,269	190.08
190.09	19009	HANCOCK OB	56	0	0		283,273	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		11,179	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		25	190.11
190.12	19012	O3PUREMED	0	0	0		0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		10,205	190.13
190.14	19014	3 WEST UNIT	3	0	0		457,298	190.14
190.15	19015	NEUROLOGY PHYSICIAN	3	0	0		11,178	190.15
190.16	19016	THORACI	0	0	0		1,473	190.16
190.17	19017	HANCOCK ENDO	1	0	0		1,892	190.17
190.18	19018	HANCOCK FOOT & ANKLE	16	0	0		6,173	190.18

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
190.19	19019	HANCOCK RHEUM	0	0	0		851	190.19
200.00		Cross Foot Adjustments				53,321	53,321	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,087	240,193	156,952	53,321	11,287,783	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,152,089		30.00
31.00	03100	INTENSIVE CARE UNIT	0	920,084		31.00
40.00	04000	SUBPROVIDER - IPF	0	395,372		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	945,061		50.00
51.00	05100	RECOVERY ROOM	0	84,758		51.00
53.00	05300	ANESTHESIOLOGY	0	257		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	910,409		54.00
60.00	06000	LABORATORY	0	253,415		60.00
65.00	06500	RESPIRATORY THERAPY	0	99,123		65.00
66.00	06600	PHYSICAL THERAPY	0	158,770		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,011		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,049		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	294,004		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	176,638		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	23,662		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	380,649		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	83,157		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,404		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	101,891		90.01
90.02	09002	DIABETES CLINIC	0	506		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	95,873		90.04
90.05	09005	PRIME TIME	0	768		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	2,829		90.06
90.07	04951	ONCOLOGY	0	515,832		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	10,856		90.08
91.00	09100	EMERGENCY	0	857,357		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	478,382		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,952,206		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	2,371,991		190.01
190.02	19002	PHYSICIAN BUILDING	0	140		190.02
190.03	19003	PRIVATE DUTY	0	9,001		190.03
190.04	19004	MARKETING	0	12,651		190.04
190.05	19005	SPORTS PHYSICALS	0	821		190.05
190.06	19006	FOUNDATION	0	94,818		190.06
190.07	19007	ASC	0	18		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	9,269		190.08
190.09	19009	HANCOCK OB	0	283,273		190.09
190.10	19010	HANCOCK WELLNESS	0	11,179		190.10
190.11	19011	MORRISTOWN CLINIC	0	25		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	10,205		190.13
190.14	19014	3 WEST UNIT	0	457,298		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	11,178		190.15
190.16	19016	THORACI	0	1,473		190.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
190.17	19017	HANCOCK ENDO	0	1,892		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	6,173		190.18
190.19	19019	HANCOCK RHEUM	0	851		190.19
200.00		Cross Foot Adjustments	0	53,321		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	11,287,783		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	351,600					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,507	52,345,870				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,441	10,242,544	-19,857,049	102,645,707		5.00
7.00	00700	OPERATION OF PLANT	17,770	1,100,863	0	7,018,865	169,431	7.00
9.00	00900	HOUSEKEEPING	2,208	1,645,295	0	2,557,235	2,208	9.00
10.00	01000	DIETARY	11,588	439,020	0	729,683	11,588	10.00
11.00	01100	CAFETERIA	0	1,030,494	0	1,255,859	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,357,725	0	1,886,279	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	179,191	0	257,591	0	14.00
15.00	01500	PHARMACY	5,982	1,936,293	0	2,088,227	5,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,974	589,122	0	1,052,105	3,974	16.00
23.00	02300	PARAMED ED PRGM	1,344	83,227	0	79,990	1,344	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,759	3,106,673	0	4,798,234	22,759	30.00
31.00	03100	INTENSIVE CARE UNIT	23,850	3,368,142	0	5,247,976	23,850	31.00
40.00	04000	SUBPROVIDER - IPF	6,376	1,188,489	0	1,655,953	6,376	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,149	3,458,691	0	7,206,764	0	50.00
51.00	05100	RECOVERY ROOM	2,120	294,667	0	447,428	2,120	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,553	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,994	3,392,806	0	6,583,352	0	54.00
60.00	06000	LABORATORY	5,844	1,683,555	0	4,803,287	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,354	1,471,246	0	1,913,691	0	65.00
66.00	06600	PHYSICAL THERAPY	3,889	1,143,934	0	1,511,268	3,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	328,056	0	396,967	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	169,616	0	204,246	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	7,493	678,016	0	1,944,049	7,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,692	0	0	153,798	4,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,809,272	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,674,291	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	2,279	66,814	0	160,434	2,279	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	257,888	0	472,820	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	2,901	505,854	0	907,540	0	90.01
90.02	09002	DIABETES CLINIC	0	39,972	0	50,261	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	2,604	101,746	0	281,169	2,604	90.04
90.05	09005	PRIME TIME	0	0	0	91,129	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	175,490	0	292,816	0	90.06
90.07	04951	ONCOLOGY	13,893	1,074,668	0	1,873,700	13,893	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	350,268	0	466,364	0	90.08
91.00	09100	EMERGENCY	22,105	2,565,761	0	4,262,190	22,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	10,830	1,276,277	0	2,544,910	10,830	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	256,946	45,302,403	-19,857,049	84,710,296	147,986	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	73,209	0	0	2,574,885	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	16,639	0	190.02
190.03	19003	PRIVATE DUTY	0	246,176	0	898,933	0	190.03
190.04	19004	MARKETING	0	175,072	0	1,460,974	0	190.04
190.05	19005	SPORTS PHYSICALS	0	69,949	0	84,697	0	190.05
190.06	19006	FOUNDATION	2,410	197,819	0	957,471	2,410	190.06
190.07	19007	ASC	0	0	0	2,114	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	855,615	0	943,385	0	190.08
190.09	19009	HANCOCK OB	6,479	2,320,072	0	5,613,262	6,479	190.09
190.10	19010	HANCOCK WELLNESS	0	789,331	0	1,183,086	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	3,000	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	683,273	0	1,086,776	0	190.13
190.14	19014	3 WEST UNIT	12,556	198,470	0	835,071	12,556	190.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
190.15	19015	NEUROLOGY PHYSICIAN	0	823,566	0	1,168,719	0	190.15
190.16	19016	THORACI	0	108,978	0	154,988	0	190.16
190.17	19017	HANCOCK ENDO	0	115,609	0	203,324	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	401,253	0	657,692	0	190.18
190.19	19019	HANCOCK RHEUM	0	58,284	0	90,395	0	190.19
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)	11,287,783	5,095,355		19,857,049	8,376,678	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.104047	0.097340		0.193452	49.440055	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		80,485		864,593	631,302	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001538		0.008423	3.726012	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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	393,860					9.00
10.00	01000	DIETARY	0	7,387				10.00
11.00	01100	CAFETERIA	6,543	0	864,579			11.00
13.00	01300	NURSING ADMINISTRATION	10,782	0	29,602	699,517		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	7,662	7,662	6,023,204	14.00
15.00	01500	PHARMACY	11,930	0	41,682	41,682	194,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	22,328	22,328	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	2,000	0	7	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	3,787	79,895	79,895	286,669	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	0	98,111	98,111	328,514	31.00
40.00	04000	SUBPROVIDER - IPF	18,095	2,458	34,194	34,194	27,257	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	53,967	53,967	1,733,144	50.00
51.00	05100	RECOVERY ROOM	16,165	0	6,663	6,663	26,174	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	95,010	95,010	213,779	54.00
60.00	06000	LABORATORY	15,335	0	60,839	60,839	1,547,006	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	43,276	43,276	68,300	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	28,895	28,895	17,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,400	0	9,604	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,969	0	3,617	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	26,615	0	16,148	0	747,032	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	2,817	0	1,048	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	20,373	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	15,577	0	72,151	90.01
90.02	09002	DIABETES CLINIC	0	0	1,292	0	1,025	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	2,849	0	761	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	4,570	0	16,715	90.06
90.07	04951	ONCOLOGY	0	0	32,192	0	78,740	90.07
90.08	04950	ANDERSON WOMENS CENTER	23,515	0	11,242	0	41,545	90.08
91.00	09100	EMERGENCY	0	0	69,860	69,860	432,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,142	34,631	34,631	77,500	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	393,860	7,387	808,671	677,013	5,945,425	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	22,504	22,504	3,910	190.03
190.04	19004	MARKETING	0	0	4,717	0	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	68	190.05
190.06	19006	FOUNDATION	0	0	6,114	0	0	190.06
190.07	19007	ASC	0	0	0	0	142	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	6,363	190.08
190.09	19009	HANCOCK OB	0	0	13,993	0	47,857	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	4,595	0	2,196	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	3,985	0	2,522	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
190.17	19017	HANCOCK ENDO	0	0	0	0	792	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	13,929	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,161,101	1,443,753	1,551,321	2,390,834	478,621	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.025951	195.445106	1.794308	3.417835	0.079463	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	103,183	422,020	13,877	21,276	7,087	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.261979	57.130093	0.016051	0.030415	0.001177	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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,387			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	94	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	156	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	3,387	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	0	0		190.13
190.14	19014	3 WEST UNIT	0	0	0		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		190.15
190.16	19016	THORACI	0	0	0		190.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 1:27 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
190.17	19017	HANCOCK ENDO	0	0	0		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	0	0		190.19
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,116,443	1,683,660	298,170		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31,164.430000	497.094774	2,981.700000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	240,193	156,952	53,321		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2,401.930000	46.339534	533.210000		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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,365,077		9,365,077	0	9,365,077	30.00
31.00	03100	INTENSIVE CARE UNIT	8,217,966		8,217,966	0	8,217,966	31.00
40.00	04000	SUBPROVIDER - IPF	3,144,281		3,144,281	0	3,144,281	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,968,783		9,968,783	0	9,968,783	50.00
51.00	05100	RECOVERY ROOM	805,344		805,344	0	805,344	51.00
53.00	05300	ANESTHESIOLOGY	36,464		36,464	0	36,464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,864,358		8,864,358	0	8,864,358	54.00
60.00	06000	LABORATORY	6,446,719		6,446,719	0	6,446,719	60.00
65.00	06500	RESPIRATORY THERAPY	2,609,150	0	2,609,150	0	2,609,150	65.00
66.00	06600	PHYSICAL THERAPY	2,257,414	0	2,257,414	0	2,257,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	491,390	0	491,390	0	491,390	67.00
68.00	06800	SPEECH PATHOLOGY	251,167	0	251,167	0	251,167	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	2,992,529		2,992,529	0	2,992,529	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	493,071		493,071	0	493,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,352,731		3,352,731	0	3,352,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,016,443		23,016,443	0	23,016,443	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	309,282		309,282	0	309,282	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	565,907		565,907	0	565,907	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,116,788		1,116,788	0	1,116,788	90.01
90.02	09002	DIABETES CLINIC	62,383		62,383	0	62,383	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	469,476		469,476	0	469,476	90.04
90.05	09005	PRIME TIME	108,758		108,758	0	108,758	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	358,990		358,990	0	358,990	90.06
90.07	04951	ONCOLOGY	2,987,061		2,987,061	0	2,987,061	90.07
90.08	04950	ANDERSON WOMENS CENTER	768,786		768,786	0	768,786	90.08
91.00	09100	EMERGENCY	6,811,210		6,811,210	0	6,811,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,193,150		4,193,150		4,193,150	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,982,522		3,982,522		3,982,522	116.00
200.00		Subtotal (see instructions)	104,047,200	0	104,047,200	0	104,047,200	200.00
201.00		Less Observation Beds	4,193,150		4,193,150		4,193,150	201.00
202.00		Total (see instructions)	99,854,050	0	99,854,050	0	99,854,050	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,600,788		6,600,788			30.00
31.00	03100	INTENSIVE CARE UNIT	10,677,393		10,677,393			31.00
40.00	04000	SUBPROVIDER - IPF	3,234,962		3,234,962			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,611,004	15,793,557	25,404,561	0.392401	0.000000	50.00
51.00	05100	RECOVERY ROOM	886,485	1,489,909	2,376,394	0.338893	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,118,247	2,043,145	3,161,392	0.011534	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,606,758	73,027,065	75,633,823	0.117201	0.000000	54.00
60.00	06000	LABORATORY	4,858,122	42,694,002	47,552,124	0.135572	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,855,759	8,128,036	10,983,795	0.237545	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	714,876	4,371,964	5,086,840	0.443775	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	560,247	798,348	1,358,595	0.361690	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	118,327	538,793	657,120	0.382224	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,424,468	14,009,543	17,434,011	0.171649	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	405,816	421,354	827,170	0.596094	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,567,061	4,146,717	9,713,778	0.345152	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,980,166	90,419,860	97,400,026	0.236308	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	457,488	457,488	0.676044	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	5,370	4,179,804	4,185,174	0.266844	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	63,998	63,998	0.974765	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	56,729	56,729	8.275767	0.000000	90.04
90.05	09005	PRIME TIME	0	472,877	472,877	0.229992	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,196,910	1,196,910	0.299931	0.000000	90.06
90.07	04951	ONCOLOGY	20,391	6,863,197	6,883,588	0.433940	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	29,798	3,963,067	3,992,865	0.192540	0.000000	90.08
91.00	09100	EMERGENCY	4,170,350	51,800,682	55,971,032	0.121692	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,892	8,684,241	8,692,133	0.482407	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,249,523	1,568,571	2,818,094			116.00
200.00		Subtotal (see instructions)	65,703,803	337,189,857	402,893,660			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	65,703,803	337,189,857	402,893,660			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.392401		50.00
51.00	05100	RECOVERY ROOM	0.338893		51.00
53.00	05300	ANESTHESIOLOGY	0.011534		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117201		54.00
60.00	06000	LABORATORY	0.135572		60.00
65.00	06500	RESPIRATORY THERAPY	0.237545		65.00
66.00	06600	PHYSICAL THERAPY	0.443775		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361690		67.00
68.00	06800	SPEECH PATHOLOGY	0.382224		68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.171649		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596094		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.345152		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236308		73.00
76.00	03020	CARDIAC	0.000000		76.00
76.01	03160	CARDIOPULMONARY	0.676044		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINIC	0.266844		90.01
90.02	09002	DIABETES CLINIC	0.974765		90.02
90.03	09003	ASTHMA CLINIC	0.000000		90.03
90.04	09004	ANDIS CLINIC	8.275767		90.04
90.05	09005	PRIME TIME	0.229992		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.299931		90.06
90.07	04951	ONCOLOGY	0.433940		90.07
90.08	04950	ANDERSON WOMENS CENTER	0.192540		90.08
91.00	09100	EMERGENCY	0.121692		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.482407		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 1:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,365,077		9,365,077	0	9,365,077	30.00
31.00	03100	INTENSIVE CARE UNIT	8,217,966		8,217,966	0	8,217,966	31.00
40.00	04000	SUBPROVIDER - IPF	3,144,281		3,144,281	0	3,144,281	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,968,783		9,968,783	0	9,968,783	50.00
51.00	05100	RECOVERY ROOM	805,344		805,344	0	805,344	51.00
53.00	05300	ANESTHESIOLOGY	36,464		36,464	0	36,464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,864,358		8,864,358	0	8,864,358	54.00
60.00	06000	LABORATORY	6,446,719		6,446,719	0	6,446,719	60.00
65.00	06500	RESPIRATORY THERAPY	2,609,150	0	2,609,150	0	2,609,150	65.00
66.00	06600	PHYSICAL THERAPY	2,257,414	0	2,257,414	0	2,257,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	491,390	0	491,390	0	491,390	67.00
68.00	06800	SPEECH PATHOLOGY	251,167	0	251,167	0	251,167	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	2,992,529		2,992,529	0	2,992,529	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	493,071		493,071	0	493,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,352,731		3,352,731	0	3,352,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,016,443		23,016,443	0	23,016,443	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	309,282		309,282	0	309,282	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	565,907		565,907	0	565,907	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,116,788		1,116,788	0	1,116,788	90.01
90.02	09002	DIABETES CLINIC	62,383		62,383	0	62,383	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	469,476		469,476	0	469,476	90.04
90.05	09005	PRIME TIME	108,758		108,758	0	108,758	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	358,990		358,990	0	358,990	90.06
90.07	04951	ONCOLOGY	2,987,061		2,987,061	0	2,987,061	90.07
90.08	04950	ANDERSON WOMENS CENTER	768,786		768,786	0	768,786	90.08
91.00	09100	EMERGENCY	6,811,210		6,811,210	0	6,811,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,193,150		4,193,150		4,193,150	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,982,522		3,982,522		3,982,522	116.00
200.00		Subtotal (see instructions)	104,047,200	0	104,047,200	0	104,047,200	200.00
201.00		Less Observation Beds	4,193,150		4,193,150		4,193,150	201.00
202.00		Total (see instructions)	99,854,050	0	99,854,050	0	99,854,050	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 1:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,600,788		6,600,788			30.00
31.00	03100	INTENSIVE CARE UNIT	10,677,393		10,677,393			31.00
40.00	04000	SUBPROVIDER - IPF	3,234,962		3,234,962			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,611,004	15,793,557	25,404,561	0.392401	0.000000	50.00
51.00	05100	RECOVERY ROOM	886,485	1,489,909	2,376,394	0.338893	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,118,247	2,043,145	3,161,392	0.011534	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,606,758	73,027,065	75,633,823	0.117201	0.000000	54.00
60.00	06000	LABORATORY	4,858,122	42,694,002	47,552,124	0.135572	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,855,759	8,128,036	10,983,795	0.237545	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	714,876	4,371,964	5,086,840	0.443775	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	560,247	798,348	1,358,595	0.361690	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	118,327	538,793	657,120	0.382224	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,424,468	14,009,543	17,434,011	0.171649	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	405,816	421,354	827,170	0.596094	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,567,061	4,146,717	9,713,778	0.345152	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,980,166	90,419,860	97,400,026	0.236308	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	457,488	457,488	0.676044	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	5,370	4,179,804	4,185,174	0.266844	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	63,998	63,998	0.974765	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	56,729	56,729	8.275767	0.000000	90.04
90.05	09005	PRIME TIME	0	472,877	472,877	0.229992	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,196,910	1,196,910	0.299931	0.000000	90.06
90.07	04951	ONCOLOGY	20,391	6,863,197	6,883,588	0.433940	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	29,798	3,963,067	3,992,865	0.192540	0.000000	90.08
91.00	09100	EMERGENCY	4,170,350	51,800,682	55,971,032	0.121692	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,892	8,684,241	8,692,133	0.482407	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,249,523	1,568,571	2,818,094			116.00
200.00		Subtotal (see instructions)	65,703,803	337,189,857	402,893,660			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	65,703,803	337,189,857	402,893,660			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 1:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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
68.01	06801	OCCUPATIONAL HEALTH	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC	0.000000		76.00
76.01	03160	CARDIOPULMONARY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINIC	0.000000		90.01
90.02	09002	DIABETES CLINIC	0.000000		90.02
90.03	09003	ASTHMA CLINIC	0.000000		90.03
90.04	09004	ANDIS CLINIC	0.000000		90.04
90.05	09005	PRIME TIME	0.000000		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000		90.06
90.07	04951	ONCOLOGY	0.000000		90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000		90.08
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,152,089	0	1,152,089	6,669	172.75	30.00
31.00	INTENSIVE CARE UNIT	920,084		920,084	4,992	184.31	31.00
40.00	SUBPROVIDER - IPF	395,372	0	395,372	2,458	160.85	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
200.00	Total (lines 30 through 199)	2,467,545		2,467,545	14,119		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,404	242,541				30.00
31.00	INTENSIVE CARE UNIT	1,973	363,644				31.00
40.00	SUBPROVIDER - IPF	1,683	270,711				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
200.00	Total (lines 30 through 199)	5,060	876,896				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	945,061	25,404,561	0.037200	3,758,747	139,825	50.00
51.00	05100	RECOVERY ROOM	84,758	2,376,394	0.035667	338,577	12,076	51.00
53.00	05300	ANESTHESIOLOGY	257	3,161,392	0.000081	456,220	37	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	910,409	75,633,823	0.012037	2,470,400	29,736	54.00
60.00	06000	LABORATORY	253,415	47,552,124	0.005329	3,493,325	18,616	60.00
65.00	06500	RESPIRATORY THERAPY	99,123	10,983,795	0.009024	1,459,468	13,170	65.00
66.00	06600	PHYSICAL THERAPY	158,770	5,086,840	0.031212	324,565	10,130	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,011	1,358,595	0.002952	211,719	625	67.00
68.00	06800	SPEECH PATHOLOGY	2,049	657,120	0.003118	56,879	177	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	294,004	17,434,011	0.016864	1,775,237	29,938	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	176,638	827,170	0.213545	263,356	56,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,662	9,713,778	0.002436	2,485,888	6,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	380,649	97,400,026	0.003908	3,639,027	14,221	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	83,157	457,488	0.181769	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,404	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	101,891	4,185,174	0.024346	3,590	87	90.01
90.02	09002	DIABETES CLINIC	506	63,998	0.007906	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	95,873	56,729	1.690017	0	0	90.04
90.05	09005	PRIME TIME	768	472,877	0.001624	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	2,829	1,196,910	0.002364	0	0	90.06
90.07	04951	ONCOLOGY	515,832	6,883,588	0.074937	20,299	1,521	90.07
90.08	04950	ANDERSON WOMENS CENTER	10,856	3,992,865	0.002719	29,798	81	90.08
91.00	09100	EMERGENCY	857,357	55,971,032	0.015318	3,970,440	60,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	515,841	8,692,133	0.059346	199	12	92.00
200.00		Total (lines 50 through 199)	5,522,120	379,562,423		24,757,734	393,365	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	6,669	0.00	1,404	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,992	0.00	1,973	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,458	0.00	1,683	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
200.00		Total (lines 30 through 199)		0	14,119		5,060	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	298,170	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	298,170	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,404,561	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,376,394	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,161,392	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	298,170	298,170	75,633,823	0.003942	54.00
60.00	06000	LABORATORY	0	0	0	47,552,124	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,983,795	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,086,840	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,358,595	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	657,120	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,434,011	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	827,170	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,713,778	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	97,400,026	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	457,488	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	4,185,174	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	63,998	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	56,729	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	472,877	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	1,196,910	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	6,883,588	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	3,992,865	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	55,971,032	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,692,133	0.000000	92.00
200.00		Total (lines 50 through 199)	0	298,170	298,170	379,562,423		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,758,747	0	3,438,950	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	338,577	0	274,903	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	456,220	0	363,365	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003942	2,470,400	9,738	19,121,131	75,375	54.00
60.00	06000	LABORATORY	0.000000	3,493,325	0	5,311,626	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,459,468	0	1,975,835	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	324,565	0	16,063	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	211,719	0	7,980	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	56,879	0	60,184	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,775,237	0	4,504,214	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	263,356	0	133,861	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	2,485,888	0	772,991	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,639,027	0	30,836,056	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	180,783	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	3,590	0	1,306,329	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	18,834	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	356,837	0	90.06
90.07	04951	ONCOLOGY	0.000000	20,299	0	1,953,180	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	29,798	0	389,823	0	90.08
91.00	09100	EMERGENCY	0.000000	3,970,440	0	8,963,498	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	199	0	2,338,836	0	92.00
200.00		Total (lines 50 through 199)		24,757,734	9,738	82,325,279	75,375	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.392401	3,438,950	0	0	1,349,447	50.00
51.00	05100	RECOVERY ROOM	0.338893	274,903	0	0	93,163	51.00
53.00	05300	ANESTHESIOLOGY	0.011534	363,365	0	0	4,191	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117201	19,121,131	0	0	2,241,016	54.00
60.00	06000	LABORATORY	0.135572	5,311,626	0	0	720,108	60.00
65.00	06500	RESPIRATORY THERAPY	0.237545	1,975,835	0	0	469,350	65.00
66.00	06600	PHYSICAL THERAPY	0.443775	16,063	0	0	7,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361690	7,980	0	0	2,886	67.00
68.00	06800	SPEECH PATHOLOGY	0.382224	60,184	0	0	23,004	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.171649	4,504,214	0	0	773,144	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596094	133,861	0	0	79,794	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.345152	772,991	0	0	266,799	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236308	30,836,056	0	13,200	7,286,807	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.676044	180,783	0	0	122,217	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.266844	1,306,329	0	0	348,586	90.01
90.02	09002	DIABETES CLINIC	0.974765	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	8.275767	18,834	0	0	155,866	90.04
90.05	09005	PRIME TIME	0.229992	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.299931	356,837	0	0	107,026	90.06
90.07	04951	ONCOLOGY	0.433940	1,953,180	0	0	847,563	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.192540	389,823	0	0	75,057	90.08
91.00	09100	EMERGENCY	0.121692	8,963,498	0	0	1,090,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.482407	2,338,836	0	0	1,128,271	92.00
200.00		Subtotal (see instructions)		82,325,279	0	13,200	17,192,209	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		82,325,279	0	13,200	17,192,209	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,119		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
90.07	04951	ONCOLOGY	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0		90.08
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	3,119		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,119		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	945,061	25,404,561	0.037200	0	0	50.00
51.00	05100	RECOVERY ROOM	84,758	2,376,394	0.035667	0	0	51.00
53.00	05300	ANESTHESIOLOGY	257	3,161,392	0.000081	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	910,409	75,633,823	0.012037	55,835	672	54.00
60.00	06000	LABORATORY	253,415	47,552,124	0.005329	293,970	1,567	60.00
65.00	06500	RESPIRATORY THERAPY	99,123	10,983,795	0.009024	85,229	769	65.00
66.00	06600	PHYSICAL THERAPY	158,770	5,086,840	0.031212	13,354	417	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,011	1,358,595	0.002952	61,303	181	67.00
68.00	06800	SPEECH PATHOLOGY	2,049	657,120	0.003118	6,760	21	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	294,004	17,434,011	0.016864	8,556	144	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	176,638	827,170	0.213545	15,234	3,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,662	9,713,778	0.002436	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	380,649	97,400,026	0.003908	235,681	921	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	83,157	457,488	0.181769	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,404	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	101,891	4,185,174	0.024346	277	7	90.01
90.02	09002	DIABETES CLINIC	506	63,998	0.007906	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	95,873	56,729	1.690017	0	0	90.04
90.05	09005	PRIME TIME	768	472,877	0.001624	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	2,829	1,196,910	0.002364	0	0	90.06
90.07	04951	ONCOLOGY	515,832	6,883,588	0.074937	47	4	90.07
90.08	04950	ANDERSON WOMENS CENTER	10,856	3,992,865	0.002719	0	0	90.08
91.00	09100	EMERGENCY	857,357	55,971,032	0.015318	68,814	1,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,692,133	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,006,279	379,562,423		845,060	9,010	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	298,170	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	298,170	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,404,561	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,376,394	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,161,392	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	298,170	298,170	75,633,823	0.003942	54.00
60.00	06000	LABORATORY	0	0	0	47,552,124	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,983,795	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,086,840	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,358,595	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	657,120	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,434,011	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	827,170	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,713,778	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	97,400,026	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	457,488	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	4,185,174	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	63,998	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	56,729	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	472,877	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	1,196,910	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	6,883,588	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	3,992,865	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	55,971,032	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,692,133	0.000000	92.00
200.00		Total (lines 50 through 199)	0	298,170	298,170	379,562,423		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003942	55,835	220	0	0	54.00
60.00	06000	LABORATORY	0.000000	293,970	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	85,229	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	13,354	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	61,303	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,760	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,556	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	15,234	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	235,681	0	0	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	277	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.000000	47	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	68,814	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		845,060	220	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,669	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,669	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,683	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,404	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)	9,365,077	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)	9,365,077	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)	9,365,077	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,404.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,971,595	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)	1,971,595	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,217,966	4,992	1,646.23	1,973	3,248,012	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)	5,625,524	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,845,131	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)	606,185	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	403,103	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,009,288	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,835,843	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)	2,986	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,404.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,193,150	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,152,089	9,365,077	0.123020	4,193,150	515,841	90.00
91.00	Nursing School cost	0	9,365,077	0.000000	4,193,150	0	91.00
92.00	Allied health cost	0	9,365,077	0.000000	4,193,150	0	92.00
93.00	All other Medical Education	0	9,365,077	0.000000	4,193,150	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1
Component CCN: 15-S037		Date/Time Prepared: 8/28/2020 1:27 pm
Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,458	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,458	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,458	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,683	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)	3,144,281	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)	3,144,281	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)	3,144,281	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,279.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,152,894	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,152,894	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	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)	172,038	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,324,932	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)	270,711	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,230	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	279,941	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,044,991	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	395,372	3,144,281	0.125743	0	0	90.00
91.00	Nursing School cost	0	3,144,281	0.000000	0	0	91.00
92.00	Allied health cost	0	3,144,281	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,144,281	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,669	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,669	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,683	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	107	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)	9,365,077	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)	9,365,077	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)	9,365,077	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,404.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	150,257	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)	150,257	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,217,966	4,992	1,646.23	19	31,278	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)	168,902	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	350,437	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)	2,986	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,404.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,193,150	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,152,089	9,365,077	0.123020	4,193,150	515,841	90.00
91.00	Nursing School cost	0	9,365,077	0.000000	4,193,150	0	91.00
92.00	Allied health cost	0	9,365,077	0.000000	4,193,150	0	92.00
93.00	All other Medical Education	0	9,365,077	0.000000	4,193,150	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,293,161		30.00
31.00	03100	INTENSIVE CARE UNIT		5,099,779		31.00
40.00	04000	SUBPROVIDER - IPF		20,856		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.392401	3,758,747	1,474,936	50.00
51.00	05100	RECOVERY ROOM	0.338893	338,577	114,741	51.00
53.00	05300	ANESTHESIOLOGY	0.011534	456,220	5,262	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117201	2,470,400	289,533	54.00
60.00	06000	LABORATORY	0.135572	3,493,325	473,597	60.00
65.00	06500	RESPIRATORY THERAPY	0.237545	1,459,468	346,689	65.00
66.00	06600	PHYSICAL THERAPY	0.443775	324,565	144,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361690	211,719	76,577	67.00
68.00	06800	SPEECH PATHOLOGY	0.382224	56,879	21,741	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.171649	1,775,237	304,718	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596094	263,356	156,985	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.345152	2,485,888	858,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236308	3,639,027	859,931	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.676044	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.266844	3,590	958	90.01
90.02	09002	DIABETES CLINIC	0.974765	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	8.275767	0	0	90.04
90.05	09005	PRIME TIME	0.229992	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.299931	0	0	90.06
90.07	04951	ONCOLOGY	0.433940	20,299	8,809	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.192540	29,798	5,737	90.08
91.00	09100	EMERGENCY	0.121692	3,970,440	483,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.482407	199	96	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		24,757,734	5,625,524	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)		24,757,734		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,235,191		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.392401	0	0	50.00
51.00	05100	RECOVERY ROOM	0.338893	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.011534	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117201	55,835	6,544	54.00
60.00	06000	LABORATORY	0.135572	293,970	39,854	60.00
65.00	06500	RESPIRATORY THERAPY	0.237545	85,229	20,246	65.00
66.00	06600	PHYSICAL THERAPY	0.443775	13,354	5,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361690	61,303	22,173	67.00
68.00	06800	SPEECH PATHOLOGY	0.382224	6,760	2,584	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.171649	8,556	1,469	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596094	15,234	9,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.345152	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236308	235,681	55,693	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.676044	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.266844	277	74	90.01
90.02	09002	DIABETES CLINIC	0.974765	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	8.275767	0	0	90.04
90.05	09005	PRIME TIME	0.229992	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.299931	0	0	90.06
90.07	04951	ONCOLOGY	0.433940	47	20	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.192540	0	0	90.08
91.00	09100	EMERGENCY	0.121692	68,814	8,374	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.482407	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		845,060	172,038	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)		845,060		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/28/2020 1:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		276,204		30.00
31.00	03100	INTENSIVE CARE UNIT		132,637		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.392401	199,960	78,465	50.00
51.00	05100	RECOVERY ROOM	0.338893	17,924	6,074	51.00
53.00	05300	ANESTHESIOLOGY	0.011534	17,666	204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117201	44,664	5,235	54.00
60.00	06000	LABORATORY	0.135572	96,265	13,051	60.00
65.00	06500	RESPIRATORY THERAPY	0.237545	38,240	9,084	65.00
66.00	06600	PHYSICAL THERAPY	0.443775	5,591	2,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361690	4,066	1,471	67.00
68.00	06800	SPEECH PATHOLOGY	0.382224	1,500	573	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.171649	48,608	8,344	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596094	6,671	3,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.345152	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236308	127,493	30,128	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.676044	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.266844	13	3	90.01
90.02	09002	DIABETES CLINIC	0.974765	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	8.275767	0	0	90.04
90.05	09005	PRIME TIME	0.229992	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.299931	0	0	90.06
90.07	04951	ONCOLOGY	0.433940	45	20	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.192540	0	0	90.08
91.00	09100	EMERGENCY	0.121692	80,467	9,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.482407	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		689,173	168,902	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)		689,173		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/28/2020 1:27 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6,285,074	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,049,278	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)	40,116	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	3,323	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	52.82	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)	2.58	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.24	31.00
32.00	Sum of lines 30 and 31	16.82	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.68	33.00
34.00	Disproportionate share adjustment (see instructions)	76,676	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	895,918	1,131,355	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	670,097	284,384	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	954,481		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 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)	9,408,948		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	9,408,948	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	679,728	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	5,015	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 intructions)	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)	9,738	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,103,429	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,103,429	61.00
62.00	Deductibles billed to program beneficiaries	1,070,200	62.00
63.00	Coinsurance billed to program beneficiaries	6,479	63.00
64.00	Allowable bad debts (see instructions)	44,470	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	28,906	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,124	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,055,656	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)		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)	34,270	70.93
70.94	HRR adjustment amount (see instructions)	-19,387	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	658,250	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	269,559	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		28,020	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,970,328	71.00
71.01	Sequestration adjustment (see instructions)		199,407	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		9,657,884	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		113,037	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		126,509	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	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
	Comparision 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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,285,074	0	6,285,074		6,285,074	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,049,278	0		2,049,278	2,049,278	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	40,116	0	40,116		40,116	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	3,323	0		3,323	3,323	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	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	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	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	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	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	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0368	0.0368	0.0368	0.0368		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	76,676	0	57,823	18,853	76,676	11.00
11.01	Uncompensated care payments	36.00	954,481	0	670,097	284,384	954,481	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,408,948	0	7,053,110	2,355,838	9,408,948	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,408,948	0	7,053,110	2,355,838	9,408,948	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 8/28/2020 1:27 pm

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	679,728	0	515,597	164,131	679,728	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition 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	7,568,707	2,519,969	10,088,676	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	674,815	0	511,374	163,441	674,815	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	4,913	0	4,223	690	4,913	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	679,728	0	515,597	164,131	679,728	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				0.086970	0.106969		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			658,250		658,250	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				269,559	269,559	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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,285,074	6,285,074		6,285,074	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,049,278		2,049,278	2,049,278	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	40,116	40,116		40,116	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	3,323		3,323	3,323	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	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	0.0368	0.0368	0.0368		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	76,676	57,823	18,853	76,676	11.00
11.01	Uncompensated care payments	36.00	954,481	670,097	284,384	954,481	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	9,408,948	7,053,110	2,355,838	9,408,948	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	9,408,948	7,053,110	2,355,838	9,408,948	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	679,728	515,597	164,131	679,728	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			7,568,707	2,519,969	10,088,676	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	674,815	511,374	163,441	674,815	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	4,913	4,223	690	4,913	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	679,728	515,597	164,131	679,728	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	658,250	658,250		658,250	28.00
29.00	Low volume adjustment on or after October 1	70.97	269,559		269,559	269,559	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	34,270	17,461	16,809	34,270	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	-19,387	-15,084	-4,303	-19,387	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	28,020	28,020	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part B Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,119	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	17,116,834	2.00
3.00	OPPS payments	13,873,024	3.00
4.00	Outlier payment (see instructions)	62,083	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	75,375	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,119	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,200	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)	13,200	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	13,200	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	10,081	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)	3,119	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)	14,010,482	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)	2,587,153	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)	11,426,448	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)	11,426,448	30.00
31.00	Primary payer payments	1,929	31.00
32.00	Subtotal (line 30 minus line 31)	11,424,519	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)	202,018	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	131,312	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	137,503	36.00
37.00	Subtotal (see instructions)	11,555,831	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-139	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	11,555,970	40.00
40.01	Sequestration adjustment (see instructions)	231,119	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	11,254,036	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	70,815	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,617,702		11,119,464	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2019	40,182	12/31/2019	134,572	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)		40,182		134,572	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)		9,657,884		11,254,036	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		113,037		70,815	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,770,921		11,324,851	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,599,196		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,599,196		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		2,811		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,602,007		0	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: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/28/2020 1:27 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037 Component CCN: 15-S037	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 8/28/2020 1:27 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,759,226	1.00
2.00	Net IPF PPS Outlier Payments	6,207	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	6.734247	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,765,433	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,765,433	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,765,433	18.00
19.00	Deductibles	133,600	19.00
20.00	Subtotal (line 18 minus line 19)	1,631,833	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	1,631,833	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,074	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	2,648	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,634,481	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	220	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,634,701	31.00
31.01	Sequestration adjustment (see instructions)	32,694	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,599,196	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	2,811	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	6,207	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII | Date/Time Prepared: 8/28/2020 1:27 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	350,437		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	350,437	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	350,437	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	408,842		8.00
9.00	Ancillary service charges	689,173	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,098,015	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,098,015	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	747,578	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	350,437	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	350,437	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	350,437	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	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)	350,437	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	350,437	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	350,437	0	40.00
41.00	Interim payments	550,228	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-199,791	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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 8/28/2020 1:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	18,659,717	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	14,505,535	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	31,719,734	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	96,639,538	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)	161,524,524	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	15,633,150	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	130,951,989	0	0	0	15.00
16.00	Accumulated depreciation	-152,976,407	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	89,637,381	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	83,246,113	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	38,923,945	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	38,923,945	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	283,694,582	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,852,134	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,416,964	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,930,728	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,199,826	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,199,826	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	264,494,756				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)	264,494,756	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	283,694,582	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 8/28/2020 1:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		238,325,478		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		26,169,410				2.00
3.00	Total (sum of line 1 and line 2)		264,494,888		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)		264,494,888		0		11.00
12.00	ROUNDING/MISC	132		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)		132		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		264,494,756		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	ROUNDING/MISC		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: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/28/2020 1:27 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,594,279		6,594,279	1.00
2.00	SUBPROVIDER - IPF	3,234,962		3,234,962	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	9,829,241		9,829,241	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,677,393		10,677,393	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)	10,677,393		10,677,393	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,506,634		20,506,634	17.00
18.00	Ancillary services	39,715,588	258,382,166	298,097,754	18.00
19.00	Outpatient services	4,189,266	77,281,909	81,471,175	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	1,249,658	1,568,571	2,818,229	26.00
27.00	NRCC	0	1,470,954	1,470,954	27.00
27.01	SELF-INSURANCE	374,629	2,381,215	2,755,844	27.01
27.02	DIETARY SERVICES	0	27,353	27,353	27.02
27.03	PRO FEES	11,622	1,791,388	1,803,010	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	66,047,397	342,903,556	408,950,953	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		139,579,962		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)		139,579,962		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 8/28/2020 1:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	408,950,953	1.00
2.00	Less contractual allowances and discounts on patients' accounts	273,210,239	2.00
3.00	Net patient revenues (line 1 minus line 2)	135,740,714	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	139,579,962	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,839,248	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME/TRANSFER	9,983,470	24.00
24.01	OTHER NON-OPERATING INCOME	20,847,418	24.01
25.00	Total other income (sum of lines 6-24)	30,830,888	25.00
26.00	Total (line 5 plus line 25)	26,991,640	26.00
27.00	LOSS ON SALE OF EQUIPMENT	822,230	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	822,230	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	26,169,410	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O | Date/Time Prepared: 8/28/2020 1:27 pm

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	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	179,937	443,700	623,637	-118,738	504,899	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	113,611	113,611	0	113,611	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	277	277	0	277	7.00
8.00	DIETARY*	0	5,333	5,333	0	5,333	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	77,500	77,500	0	77,500	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	12,268	12,268	0	12,268	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	119,867	119,867	0	119,867	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						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		12,125	12,125	0	12,125	25.00
26.00	PHYSICIAN SERVICES**	1,743	6,775	8,518	0	8,518	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	782,094	79,715	861,809	0	861,809	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	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 & HOMEMAKER SERVICES**	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	28,320	28,320	0	28,320	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)**	143,679	3,636	147,315	0	147,315	46.00
	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*	169,033	12,264	181,297	0	181,297	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
100.00	TOTAL	1,276,486	915,391	2,191,877	-118,738	2,073,139	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O | Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		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*	-149	504,750		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	113,611		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	277		7.00
8.00	DIETARY*	0	5,333		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	77,500		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	12,268		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	119,867		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				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	12,125		25.00
26.00	PHYSICIAN SERVICES**	0	8,518		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	861,809		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		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 & HOMEMAKER SERVICES**	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	28,320		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	147,315		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	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	181,297		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	-149	2,072,990		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0037 Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-2 | Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	625	6,775	7,400	0	7,400	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	280,379	28,578	308,957	0	308,957	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	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 & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	10,153	10,153	0	10,153	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)	51,509	1,303	52,812	0	52,812	46.00
100.00	TOTAL *	332,513	46,809	379,322	0	379,322	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	7,400		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	308,957		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		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 & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	10,153		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	52,812		46.00
100.00	TOTAL *	0	379,322		100.00

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

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-3 | Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		2,503	2,503	0	2,503	25.00
26.00	PHYSICIAN SERVICES	231	0	231	0	231	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	103,565	10,556	114,121	0	114,121	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	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 & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	3,750	3,750	0	3,750	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)	19,026	481	19,507	0	19,507	46.00
100.00	TOTAL *	122,822	17,290	140,112	0	140,112	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	2,503		25.00
26.00	PHYSICIAN SERVICES	0	231		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	114,121		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		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 & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	3,750		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	19,507		46.00
100.00	TOTAL *	0	140,112		100.00

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

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-4 | Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		9,622	9,622	0	9,622	25.00
26.00	PHYSICIAN SERVICES	887	0	887	0	887	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	398,150	40,581	438,731	0	438,731	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	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 & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	14,417	14,417	0	14,417	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)	73,144	1,852	74,996	0	74,996	46.00
100.00	TOTAL *	472,181	66,472	538,653	0	538,653	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	9,622		25.00
26.00	PHYSICIAN SERVICES	0	887		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	438,731		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		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 & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	14,417		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	74,996		46.00
100.00	TOTAL *	0	538,653		100.00

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

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-5 | Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	347,687	347,687	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	124,233	124,233	3.00
4.00	ADMINISTRATIVE & GENERAL	504,750	554,457	1,059,207	4.00
5.00	PLANT OPERATION & MAINTENANCE	113,611	535,436	649,047	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	277	0	277	7.00
8.00	DIETARY	5,333	223,198	228,531	8.00
9.00	NURSING ADMINISTRATION	0	118,363	118,363	9.00
10.00	ROUTINE MEDICAL SUPPLIES	77,500	6,158	83,658	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	12,268		12,268	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	119,867	0	119,867	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	379,322		379,322	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	140,112		140,112	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	538,653		538,653	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	181,297		181,297	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
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,072,990	1,909,532	3,982,522	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6 Part I
Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

	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 & FIXT	347,687	347,687				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	124,233	0	0	124,233		3.00
4.00	ADMINISTRATIVE & GENERAL	1,059,207	0	0	0	1,059,207	4.00
5.00	PLANT OPERATION & MAINTENANCE	649,047	0	0	0	649,047	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	277	0	0	0	277	7.00
8.00	DIETARY	228,531	0	0	0	228,531	8.00
9.00	NURSING ADMINISTRATION	118,363	0	0	0	118,363	9.00
10.00	ROUTINE MEDICAL SUPPLIES	83,658	0	0	0	83,658	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	12,268	0	0	0	12,268	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	119,867	0	0	0	119,867	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	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	379,322			44,537	423,859	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	140,112	0	0	16,451	156,563	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	538,653	347,687	0	63,245	949,585	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	181,297	0	0	0	181,297	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		99.00
100.00	TOTAL	3,982,522	347,687	0	124,233	3,982,522	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6 Part I
Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

	Descriptions	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	1,059,207					4.00
5.00	PLANT OPERATION & MAINTENANCE	235,170	884,217				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	100	0		377		7.00
8.00	DIETARY	82,804	0		0	311,335	8.00
9.00	NURSING ADMINISTRATION	42,887	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	30,312	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	4,445	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	43,432	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	153,577					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	56,728	0	0	188	131,576	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	344,062	884,217	0	189	179,759	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	65,690	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						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	1,059,207	884,217	0	377	311,335	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0037 Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-6 Part I Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

	Descriptions	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	161,250					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	113,970				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			16,713		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						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	145,436	102,792	0	5,571	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	6,683	4,724	0	5,571	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	9,131	6,454	0	5,571	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	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	161,250	113,970	0	16,713	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-6 Part I | Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	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	163,299					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		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	54,433	0	0		885,668	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	54,433	0	0	0	416,466	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	54,433	0	0	0	2,433,401	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		246,987	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	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	163,299	0	0	0	3,982,522	100.00

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

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6
Part II
Date/Time Prepared:
8/28/2020 1:27 pm

Hospice I

	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	317					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	927,516			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-1,059,207	2,923,315	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	649,047	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	277	7.00
8.00	DIETARY	0	0	0	0	228,531	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	118,363	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	83,658	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	12,268	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	119,867	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	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			332,513	0	423,859	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	122,822	0	156,563	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	317	0	472,181	0	949,585	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	181,297	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		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. O-6, Part I)	347,687	0	124,233		1,059,207	100.00
101.00	UNIT COST MULTIPLIER	1,096.804416	0.000000	0.133942		0.362331	101.00

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

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6
Part II
Date/Time Prepared:
8/28/2020 1:27 pm

Hospice I

	Cost Center Descriptions	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	317					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		100			7.00
8.00	DIETARY	0		0	336		8.00
9.00	NURSING ADMINISTRATION	0		0		3,426	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			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					3,090	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	50	142	142	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	317	0	50	194	194	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						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. O-6, Part I)	884,217	0	377	311,335	161,250	100.00
101.00	UNIT COST MULTIPLIER	2,789.328076	0.000000	3.770000	926.592262	47.066550	101.00

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

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6
Part II
Date/Time Prepared:
8/28/2020 1:27 pm

Hospice I

	Cost Center Descriptions	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	3,426					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			99			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	99	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	3,090	0	33	0	33	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	142	0	33	0	33	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	194	0	33	0	33	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						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	113,970	0	16,713	0	163,299	100.00
101.00	UNIT COST MULTIPLIER	33.266200	0.000000	168.818182	0.000000	1,649.484848	101.00

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

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6
Part II
Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		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 RESPITE 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					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. O-6, Part I)	0	0	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: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-7 | Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

	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	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.443775	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.361690	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.382224	0	0	0	3.00
3.01	OCCUPATIONAL HEALTH	68.01	0.000000	0	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.236308	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.135572	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.596094	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CARDIAC	76.00	0.000000	0	0	0	10.00
10.01	CARDIOPULMONARY	76.01	0.676044	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC 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
3.01	OCCUPATIONAL HEALTH	0	0	0	0	0	3.01
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
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	CARDIAC	0	0	0	0	0	10.00
10.01	CARDIOPULMONARY	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-8 | Date/Time Prepared: 8/28/2020 1:27 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			885,668	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			3,090	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			286.62	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,090	0		9.00
10.00	Program cost (line 8 times line 9)	885,656	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			416,466	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			142	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			2,932.86	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	142	0		14.00
15.00	Program cost (line 13 times line 14)	416,466	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			2,433,401	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			194	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			12,543.30	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	194	0		19.00
20.00	Program cost (line 18 times line 19)	2,433,400	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,735,535	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			3,426	22.00
23.00	Average cost per diem (line 21 divided by line 22)			1,090.35	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/28/2020 1:27 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	674,815	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	4,913	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)	24.05	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)	679,728	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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037
Component CCN: 15-3987
Period: From 01/01/2019 To 12/31/2019
Worksheet M-1
Date/Time Prepared: 8/28/2020 1:27 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	20,024	0	20,024	0	20,024	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	144,399	0	144,399	0	144,399	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	82,183	0	82,183	0	82,183	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	11,282	0	11,282	0	11,282	9.00
10.00	Subtotal (sum of lines 1 through 9)	257,888	0	257,888	0	257,888	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	20,373	20,373	0	20,373	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,373	20,373	0	20,373	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	257,888	20,373	278,261	0	278,261	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	32,161	32,161	-32,161	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	32,161	32,161	-32,161	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	174,619	174,619	0	174,619	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	174,619	174,619	0	174,619	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	257,888	227,153	485,041	-32,161	452,880	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 8/28/2020 1:27 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	20,024		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	144,399		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	82,183		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	11,282		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	257,888		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	20,373		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,373		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	278,261		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-5,163	169,456		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-5,163	169,456		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,163	447,717		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 8/28/2020 1:27 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.08	117	4,200	336		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.98	3,127	2,100	2,058		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.06	3,244		2,394	3,244	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.06	3,244			3,244	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					278,261	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					278,261	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					169,456	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					118,190	15.00
16.00	Total overhead (sum of lines 14 and 15)					287,646	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					287,646	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					287,646	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					565,907	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/28/2020 1:27 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		565,907	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		19,168	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		546,739	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,244	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,244	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		168.54	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	84.70	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	84.70	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	297	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	25,156	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	25,156	16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,175	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,275	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,476	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		11,491	16.04
16.05	Total program cost (see instructions)	0	14,967	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,316	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,117	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		14,967	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,008	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		24,975	22.00
23.00	Allowable bad debts (see instructions)		326	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		212	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		25,187	26.00
26.01	Sequestration adjustment (see instructions)		504	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		14,101	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		10,582	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 8/28/2020 1:27 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	257,888	257,888	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001035	0.009424	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	267	2,430	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,112	2,616	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,379	5,046	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	278,261	278,261	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	287,646	287,646	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015737	0.018134	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,527	5,216	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,906	10,262	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	28	166	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	318.07	61.82	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	20	59	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	6,361	3,647	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		19,168	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		10,008	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/28/2020 1:27 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		14,101	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	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	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		14,101	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	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		10,582	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		24,683	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00