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: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 8:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/29/2020 Time: 8:37 am
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 IU HEALTH FRANKFORT HOSPITAL (15-1316) 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) TODD WILLIAMS
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
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	129,542	391,734	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	232,356	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
200.00	Total	0	361,898	391,734	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:37 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 SOUTH JACKSON STREET	PO Box:			1.00
2.00	City: FRANKFORT	State: IN	Zip Code: 46041	County: CLINTON	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	IU HEALTH FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH FRANKFORT HOSPITAL	15Z316	99915		01/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	2		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:37 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

		V	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

		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.	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 8:37 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:37 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:37 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:37 am

		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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	30,613	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:37 am

	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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)	Y	62	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/29/2020 8:37 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	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)	Y			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.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	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	04/01/2020	Y	04/01/2020 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:37 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:37 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GOVERNMENT PROGRAMS DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 6/29/2020 8:37 am

	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	25	9,125	28,872.00	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)		25	9,125	28,872.00	0	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)		25	9,125	28,872.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:37 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	707	2	1,203			1.00
2.00	HMO and other (see instructions)	232	102				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	183	0	183			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	175			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	890	2	1,561			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)	890	2	1,561	0.00	100.98	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	100.98	27.00
28.00	Observation Bed Days		1	486			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			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: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:37 am

	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	203	1	339	1.00
2.00	HMO and other (see instructions)			59	25		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	203	1	339	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 6/29/2020 8:37 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.455810	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,248,405	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	9,277,033	6.00
7.00	Medicaid cost (line 1 times line 6)	4,228,564	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)	1,980,159	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)	5,455	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	10,438	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	4,758	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)	1,980,159	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,321,692	46,159	2,367,851	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,058,250	46,159	1,104,409	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)	1,058,250	46,159	1,104,409	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)	2,332,160	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	316,748	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	487,305	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,844,855	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,011,460	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,115,869	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,096,028	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	16,021	16,021	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	1,621,245	1,621,245	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB		0	0	58,130	58,130	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	39,458	40,714	80,172	1,051,555	1,131,727	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	747,102	4,486,112	5,233,214	670,753	5,903,967	5.00
7.00	00700	OPERATION OF PLANT	406,642	3,370,258	3,776,900	-3,248,417	528,483	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	1,257,193	1,257,193	7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	37,914	37,914	8.00
9.00	00900	HOUSEKEEPING	248,855	229,762	478,617	-113,992	364,625	9.00
10.00	01000	DIETARY	138,628	260,928	399,556	-272,851	126,705	10.00
11.00	01100	CAFETERIA	0	0	0	217,315	217,315	11.00
13.00	01300	NURSING ADMINISTRATION	816,986	199,431	1,016,417	-96,363	920,054	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	148,071	148,071	338,611	486,682	14.00
15.00	01500	PHARMACY	380,630	982,414	1,363,044	-342,209	1,020,835	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	947,509	746,608	1,694,117	-280,852	1,413,265	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	253,194	1,004,350	1,257,544	-498,081	759,463	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	672,484	292,791	965,275	-207,906	757,369	54.00
60.00	06000	LABORATORY	0	1,159,585	1,159,585	-12,930	1,146,655	60.00
66.00	06600	PHYSICAL THERAPY	262	530,958	531,220	-10,980	520,240	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	187,033	187,033	0	187,033	67.00
68.00	06800	SPEECH PATHOLOGY	69,986	19,885	89,871	-14,612	75,259	68.00
69.00	06900	ELECTROCARDIOLOGY	42,558	17,326	59,884	-8,607	51,277	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	35,129	35,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,479	14,479	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	218,789	218,789	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	105,039	105,039	73.01
76.00	03160	CARDIOPULMONARY	664,901	221,649	886,550	-156,889	729,661	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,204	11,204	-11,204	0	90.00
91.00	09100	EMERGENCY	1,080,883	2,595,817	3,676,700	-363,282	3,313,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,510,078	16,504,896	23,014,974	2,998	23,017,972	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	9,311	9,311	-2,998	6,313	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	6,510,078	16,514,207	23,024,285	0	23,024,285	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	16,021		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	124,348	1,745,593		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB	0	58,130		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	390,540	1,522,267		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-95,125	5,808,842		5.00
7.00	00700	OPERATION OF PLANT	-36,598	491,885		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	-44,344	1,212,849		7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,914		8.00
9.00	00900	HOUSEKEEPING	0	364,625		9.00
10.00	01000	DIETARY	0	126,705		10.00
11.00	01100	CAFETERIA	-71,459	145,856		11.00
13.00	01300	NURSING ADMINISTRATION	30,381	950,435		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,635	511,317		14.00
15.00	01500	PHARMACY	-361,960	658,875		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-273,292	1,139,973		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-141,268	618,195		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-211	757,158		54.00
60.00	06000	LABORATORY	0	1,146,655		60.00
66.00	06600	PHYSICAL THERAPY	0	520,240		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	187,033		67.00
68.00	06800	SPEECH PATHOLOGY	0	75,259		68.00
69.00	06900	ELECTROCARDIOLOGY	0	51,277		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,129		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,479		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	218,789		73.00
73.01	07301	ONCOLOGY DRUGS	0	105,039		73.01
76.00	03160	CARDIOPULMONARY	77,972	807,633		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-675,532	2,637,886		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				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,051,913	21,966,059		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	6,313		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	LEASED SPACE	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,051,913	21,972,372		200.00

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:37 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	87,570	129,745		1.00
	0		87,570	129,745		
	B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	218,789		1.00
2.00	ONCOLOGY DRUGS	73.01	0	105,039		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
	TOTALS		0	323,828		
	C - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	344,207		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	35,129		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,479		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	156		4.00
5.00	NURSING ADMINISTRATION	13.00	0	88		5.00
6.00	MOB	192.02	0	2		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
	TOTALS		0	394,061		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	37,914		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
	TOTALS		0	37,914		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,071,531		1.00
2.00	CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	29,416		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	740,181		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
	TOTALS		0	1,841,128		
	F - OTHER CAPITAL					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	549,167		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,021		2.00
3.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	547		3.00
4.00	CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	25,714		4.00
	TOTALS		0	591,449		
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT - HOSPITAL	7.01	0	1,257,193		1.00
	TOTALS		0	1,257,193		
	H - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,051,555		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:37 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	TOTALS		0	1,051,555		
	I - HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	0	2,055		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
	TOTALS		0	2,055		
	K - MOB MAINTENANCE AND RENT					
1.00	CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	3,000		1.00
	TOTALS		0	3,000		
	L - ONCOLOGY					
1.00	OPERATING ROOM	50.00	0	11,204		1.00
	TOTALS		0	11,204		
500.00	Grand Total: Increases		87,570	5,643,132		500.00

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:37 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	87,570	129,745	0		1.00
	0		87,570	129,745			
	B - DRUGS						
1.00	PHARMACY	15.00	0	286,540	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,445	0		2.00
3.00	OPERATING ROOM	50.00	0	1,135	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,836	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	96	0		5.00
6.00	CARDIOPULMONARY	76.00	0	1,897	0		6.00
7.00	EMERGENCY	91.00	0	8,879	0		7.00
	TOTALS		0	323,828			
	C - MEDICAL SUPPLIES						
1.00	OPERATION OF PLANT	7.00	0	34,178	0		1.00
2.00	HOUSEKEEPING	9.00	0	5,376	0		2.00
3.00	DIETARY	10.00	0	38	0		3.00
4.00	PHARMACY	15.00	0	2,846	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	70,757	0		5.00
6.00	OPERATING ROOM	50.00	0	80,586	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,898	0		7.00
8.00	LABORATORY	60.00	0	12,930	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	7,562	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	5,874	0		10.00
11.00	CARDIOPULMONARY	76.00	0	10,994	0		11.00
12.00	EMERGENCY	91.00	0	144,022	0		12.00
	TOTALS		0	394,061			
	D - LAUNDRY						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,596	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	10,108	0		2.00
3.00	OPERATING ROOM	50.00	0	1,830	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,447	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	2,417	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	927	0		6.00
7.00	CARDIOPULMONARY	76.00	0	250	0		7.00
8.00	EMERGENCY	91.00	0	13,339	0		8.00
	TOTALS		0	37,914			
	E - DEPRECIATION						
1.00	OPERATION OF PLANT	7.00	0	1,305,648	9		1.00
2.00	HOUSEKEEPING	9.00	0	1,736	9		2.00
3.00	DIETARY	10.00	0	6,107	0		3.00
4.00	PHARMACY	15.00	0	1,488	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	23,645	0		5.00
6.00	OPERATING ROOM	50.00	0	380,194	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,931	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	631	0		8.00
9.00	CARDIOPULMONARY	76.00	0	53,958	0		9.00
10.00	EMERGENCY	91.00	0	13,790	0		10.00
	TOTALS		0	1,841,128			
	F - OTHER CAPITAL						
1.00	OPERATION OF PLANT	7.00	0	549,167	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	16,021	12		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	547	12		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	25,714	13		4.00
	TOTALS		0	591,449			
	G - OPERATION OF PLANT						
1.00	OPERATION OF PLANT	7.00	0	1,257,193	0		1.00
	TOTALS		0	1,257,193			
	H - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,302	0		1.00
2.00	OPERATION OF PLANT	7.00	0	102,231	0		2.00
3.00	HOUSEKEEPING	9.00	0	108,935	0		3.00
4.00	DIETARY	10.00	0	49,349	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	96,451	0		5.00
6.00	PHARMACY	15.00	0	50,747	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	171,733	0		7.00
8.00	OPERATING ROOM	50.00	0	45,444	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	110,667	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	11	0		10.00
11.00	SPEECH PATHOLOGY	68.00	0	14,612	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	1,806	0		12.00
13.00	CARDIOPULMONARY	76.00	0	89,762	0		13.00
14.00	EMERGENCY	91.00	0	182,505	0		14.00
	TOTALS		0	1,051,555			

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:37 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - HOUSEKEEPING						
1.00	DIETARY	10.00	0	42	0		1.00
2.00	PHARMACY	15.00	0	588	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	164	0		3.00
4.00	OPERATING ROOM	50.00	0	96	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	127	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	263	0		6.00
7.00	CARDIOPULMONARY	76.00	0	28	0		7.00
8.00	EMERGENCY	91.00	0	747	0		8.00
	TOTALS		0	2,055			
	K - MOB MAINTENANCE AND RENT						
1.00	MOB	192.02	0	3,000	10		1.00
	TOTALS		0	3,000			
	L - ONCOLOGY						
1.00	CLINIC	90.00	0	11,204	0		1.00
	TOTALS		0	11,204			
500.00	Grand Total: Decreases		87,570	5,643,132			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 6/29/2020 8:37 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	807,164	143,883	0	143,883	0	1.00
2.00	Land Improvements	0	16,117	0	16,117	0	2.00
3.00	Buildings and Fixtures	47,253	0	0	0	11,938	3.00
4.00	Building Improvements	1,425,477	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,339,042	157,727	0	157,727	751,574	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	7,618,936	317,727	0	317,727	763,512	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	7,618,936	317,727	0	317,727	763,512	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	951,047	0	1.00
2.00	Land Improvements	16,117	0	2.00
3.00	Buildings and Fixtures	35,315	0	3.00
4.00	Building Improvements	1,425,477	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,745,195	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	7,173,151	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	7,173,151	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 6/29/2020 8:37 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	1.02
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 6/29/2020 8:37 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	7,013,152	0	7,013,152	0.977695	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	160,000	0	160,000	0.022305	0	1.02
3.00	Total (sum of lines 1-2)	7,173,152	0	7,173,152	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,014,669	549,167	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	0	29,416	3,000	1.02
3.00	Total (sum of lines 1-2)	0	0	0	1,044,085	552,167	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	16,021	0	0	16,021	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	181,210	547	0	0	1,745,593	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	25,714	0	58,130	1.02
3.00	Total (sum of lines 1-2)	181,210	16,568	25,714	0	1,819,744	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:37 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)	B	435,661	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - MOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	1.02
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	-1,251,223			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,729,508			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-71,459	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	-118,772	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - MOB		0	CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	26.02
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:37 am

	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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	EMPLOYEE BENEFITS	A	-1,052,899	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MEDICAID HAF FEES	A	-802,576	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-13,322	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ACCRUED PTO	A	-33,811	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	ACCRUED PTO	A	12,011	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CONTRIBUTION EXPENSE	A	-4,643	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	AMORTIZED START UP COSTS	A	670,351	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING	A	-124	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MARKETING	A	-211	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	MARKETING	A	-34	EMERGENCY	91.00	0	33.09
33.10	DEPRECIATION ON CAPITALIZED ASSETS	A	61,910	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.10
33.11	START UP COST NEW HOSPITAL	A	-612,280	ADMINISTRATIVE & GENERAL	5.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,051,913				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:37 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE	-254,451	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,477,250	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,811,551	3,418,885	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	765,560	502,768	3.01
3.02	7.00	OPERATION OF PLANT	RELATED PARTY	49,919	86,517	3.02
3.03	7.01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	56,744	101,088	3.03
4.00	13.00	NURSING ADMINISTRATION	RELATED PARTY	30,381	0	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	RELATED PARTY	162,587	137,952	4.01
4.02	15.00	PHARMACY	RELATED PARTY	217,946	579,906	4.02
4.03	30.00	ADULTS & PEDIATRICS	RELATED PARTY	105,726	48,372	4.03
4.04	50.00	OPERATING ROOM	RELATED PARTY	193,052	92,266	4.04
4.05	76.00	CARDIOPULMONARY	RELATED PARTY	77,972	0	4.05
4.06	91.00	EMERGENCY	RELATED PARTY	71,964	68,939	4.06
4.07	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	330,646	330,646	4.07
4.08	50.00	OPERATING ROOM	SHARED EMPLOYEES	262,054	262,054	4.08
4.09	60.00	LABORATORY	SHARED EMPLOYEES	1,138,281	1,138,281	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,497,182	6,767,674	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/29/2020 8:37 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-254,451	11		1.00
2.00	1,477,250	0		2.00
3.00	392,666	0		3.00
3.01	262,792	0		3.01
3.02	-36,598	0		3.02
3.03	-44,344	0		3.03
4.00	30,381	0		4.00
4.01	24,635	0		4.01
4.02	-361,960	0		4.02
4.03	57,354	0		4.03
4.04	100,786	0		4.04
4.05	77,972	0		4.05
4.06	3,025	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
5.00	1,729,508			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/29/2020 8:37 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	330,646	330,646	0	0	0	1.00
2.00	50.00	OPERATING ROOM	242,054	242,054	0	0	0	2.00
3.00	91.00	EMERGENCY	1,977,905	678,523	1,299,382	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,550,605	1,251,223	1,299,382		0	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	30.00	ADULTS & PEDIATRICS	0	0	0	330,646		1.00
2.00	50.00	OPERATING ROOM	0	0	0	242,054		2.00
3.00	91.00	EMERGENCY	0	0	0	678,523		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,251,223		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/29/2020 8:37 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					288	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					15	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.80	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	6,578.20	98.32	1,105.96	0.00	9.00
10.00	AHSEA (see instructions)	0.00	84.94	55.21	33.60	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.47	42.47	27.61			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					558,752	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					5,428	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					564,180	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					37,160	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					601,340	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					601,340	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					12,231	24.00
25.00	Assistants (line 4 times column 3, line 11)					414	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,645	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,757	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					14,402	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					14,402	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/29/2020 8:37 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.94	55.21	33.60	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	601,340		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	14,402		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	615,742		63.00
64.00	Total cost of outside supplier services (from your records)	506,873		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	12,645		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,757		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,402		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,757		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,757		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/29/2020 8:37 am

		Occupational Therapy	Cost
			1.00
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	192	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	221	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.80	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,405.15	1,672.41	509.80	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.52	55.56	33.84	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.26	40.26	27.78			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	113,143	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	92,919	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	206,062	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	17,252	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	223,314	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	223,314	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	7,730	24.00
25.00	Assistants (line 4 times column 3, line 11)	6,139	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	13,869	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,395	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	16,264	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	16,264	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/29/2020 8:37 am
		Occupational Therapy	Cost

		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.52	55.56	33.84	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	223,314	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	16,264	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	239,578	63.00
64.00	Total cost of outside supplier services (from your records)	184,908	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,869	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,395	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	16,264	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,395	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,395	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - MOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	16,021	16,021				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,745,593	0	1,745,593			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB	58,130	0	0	58,130		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,522,267	59	6,892	0	1,529,218	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,808,842	2,650	307,981	0	176,565	5.00
7.00	00700	OPERATION OF PLANT	491,885	238	27,617	0	96,103	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,212,849	2,999	348,280	0	0	7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	37,914	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	364,625	528	61,386	0	58,813	9.00
10.00	01000	DIETARY	126,705	378	43,917	0	12,067	10.00
11.00	01100	CAFETERIA	145,856	648	75,334	0	20,696	11.00
13.00	01300	NURSING ADMINISTRATION	950,435	88	10,247	0	193,081	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	511,317	290	33,703	0	0	14.00
15.00	01500	PHARMACY	658,875	271	31,499	0	89,955	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,139,973	1,718	199,684	0	223,928	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	618,195	1,453	168,843	0	59,838	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	757,158	740	85,993	0	158,930	54.00
60.00	06000	LABORATORY	1,146,655	562	65,300	0	0	60.00
66.00	06600	PHYSICAL THERAPY	520,240	415	48,243	0	62	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,033	182	21,153	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	75,259	99	11,547	0	16,540	68.00
69.00	06900	ELECTROCARDIOLOGY	51,277	297	34,460	0	10,058	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,129	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,479	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,789	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	105,039	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	807,633	388	45,069	0	157,138	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,637,886	708	82,308	0	255,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,966,059	14,711	1,709,456	0	1,529,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	6,313	999	0	58,130	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	311	36,137	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,972,372	16,021	1,745,593	58,130	1,529,218	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - MOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,296,038	6,296,038				5.00
7.00	00700	OPERATION OF PLANT	615,843	247,339	863,182			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,564,128	628,196	197,881	2,390,205		7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	37,914	15,227	0	0	0	8.00
9.00	00900	HOUSEKEEPING	485,352	194,930	34,878	139,098	0	9.00
10.00	01000	DIETARY	183,067	73,525	24,953	99,516	0	10.00
11.00	01100	CAFETERIA	242,534	97,408	42,803	170,705	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,153,851	463,418	5,822	23,220	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	545,310	219,011	19,149	76,370	0	14.00
15.00	01500	PHARMACY	780,600	313,510	17,897	71,376	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,565,303	628,668	113,455	452,481	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	848,329	340,712	95,932	382,595	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,002,821	402,760	48,858	194,857	0	54.00
60.00	06000	LABORATORY	1,212,517	486,980	37,102	147,969	0	60.00
66.00	06600	PHYSICAL THERAPY	568,960	228,510	27,410	109,318	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,368	83,686	12,018	47,932	0	67.00
68.00	06800	SPEECH PATHOLOGY	103,445	41,546	6,561	26,165	0	68.00
69.00	06900	ELECTROCARDIOLOGY	96,092	38,593	19,579	78,084	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,129	14,109	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,479	5,815	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,789	87,872	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	105,039	42,186	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,010,228	405,735	25,607	102,125	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,976,346	1,195,380	46,765	186,508	0	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,870,482	6,255,116	776,670	2,308,319	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	65,442	26,283	65,980	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	36,448	14,639	20,532	81,886	0	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,972,372	6,296,038	863,182	2,390,205	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	53,141					8.00
9.00	00900	HOUSEKEEPING	0	854,258				9.00
10.00	01000	DIETARY	0	37,765	418,826			10.00
11.00	01100	CAFETERIA	0	64,780	0	618,230		11.00
13.00	01300	NURSING ADMINISTRATION	0	8,812	0	72,109	1,727,232	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,981	0	0	0	14.00
15.00	01500	PHARMACY	0	27,086	0	30,755	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,141	171,708	418,826	115,712	728,687	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	145,189	0	32,843	103,936	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,945	0	75,081	0	54.00
60.00	06000	LABORATORY	0	56,152	0	54,203	0	60.00
66.00	06600	PHYSICAL THERAPY	0	41,484	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,189	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,929	0	6,183	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,632	0	5,139	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	38,755	0	79,497	209	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	70,777	0	146,708	894,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,141	823,184	418,826	618,230	1,727,232	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	31,074	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,141	854,258	418,826	618,230	1,727,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	888,821					14.00
15.00	01500	PHARMACY	7,552	1,248,776				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	171,872	15,954	0	4,435,807	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,985	3,668	0	2,073,189	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,410	1,077	0	1,845,809	0	54.00
60.00	06000	LABORATORY	31,504	0	0	2,026,427	0	60.00
66.00	06600	PHYSICAL THERAPY	17,572	0	0	993,254	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	370,193	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	193,829	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,271	0	0	281,390	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,905	0	0	133,143	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,583	0	0	54,877	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	807,269	0	1,113,930	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	387,564	0	534,789	0	73.01
76.00	03160	CARDIOPULMONARY	24,193	594	0	1,686,943	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	336,974	32,650	0	5,886,508	0	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	888,821	1,248,776	0	21,630,088	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	0	0	157,705	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	184,579	0	194.00
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)	888,821	1,248,776	0	21,972,372	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - MOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,435,807		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,073,189		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,845,809		54.00
60.00	06000	LABORATORY	2,026,427		60.00
66.00	06600	PHYSICAL THERAPY	993,254		66.00
67.00	06700	OCCUPATIONAL THERAPY	370,193		67.00
68.00	06800	SPEECH PATHOLOGY	193,829		68.00
69.00	06900	ELECTROCARDIOLOGY	281,390		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,143		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,877		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,113,930		73.00
73.01	07301	ONCOLOGY DRUGS	534,789		73.01
76.00	03160	CARDIOPULMONARY	1,686,943		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	5,886,508		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,630,088		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.02	19202	MOB	157,705		192.02
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	LEASED SPACE	184,579		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	21,972,372		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - MOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	59	6,892	0	6,951	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,650	307,981	0	310,631	5.00
7.00	00700	OPERATION OF PLANT	0	238	27,617	0	27,855	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	2,999	348,280	0	351,279	7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	528	61,386	0	61,914	9.00
10.00	01000	DIETARY	0	378	43,917	0	44,295	10.00
11.00	01100	CAFETERIA	0	648	75,334	0	75,982	11.00
13.00	01300	NURSING ADMINISTRATION	0	88	10,247	0	10,335	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	290	33,703	0	33,993	14.00
15.00	01500	PHARMACY	0	271	31,499	0	31,770	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,718	199,684	0	201,402	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,453	168,843	0	170,296	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	740	85,993	0	86,733	54.00
60.00	06000	LABORATORY	0	562	65,300	0	65,862	60.00
66.00	06600	PHYSICAL THERAPY	0	415	48,243	0	48,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	182	21,153	0	21,335	67.00
68.00	06800	SPEECH PATHOLOGY	0	99	11,547	0	11,646	68.00
69.00	06900	ELECTROCARDIOLOGY	0	297	34,460	0	34,757	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	388	45,069	0	45,457	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	708	82,308	0	83,016	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,711	1,709,456	0	1,724,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	999	0	58,130	59,129	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	311	36,137	0	36,448	194.00
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	16,021	1,745,593	58,130	1,819,744	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - MOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,951					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	802	311,433				5.00
7.00	00700	OPERATION OF PLANT	437	12,234	40,526			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	31,073	9,290	391,642		7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	753	0	0	0	8.00
9.00	00900	HOUSEKEEPING	267	9,642	1,637	22,792	0	9.00
10.00	01000	DIETARY	55	3,637	1,172	16,306	0	10.00
11.00	01100	CAFETERIA	94	4,818	2,010	27,971	0	11.00
13.00	01300	NURSING ADMINISTRATION	877	22,922	273	3,805	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,833	899	12,513	0	14.00
15.00	01500	PHARMACY	409	15,507	840	11,695	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,018	31,096	5,327	74,141	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272	16,853	4,504	62,689	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	722	19,922	2,294	31,928	0	54.00
60.00	06000	LABORATORY	0	24,088	1,742	24,245	0	60.00
66.00	06600	PHYSICAL THERAPY	0	11,303	1,287	17,912	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,139	564	7,854	0	67.00
68.00	06800	SPEECH PATHOLOGY	75	2,055	308	4,287	0	68.00
69.00	06900	ELECTROCARDIOLOGY	46	1,909	919	12,794	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	698	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	288	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,346	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	2,087	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	714	20,069	1,202	16,733	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,163	59,137	2,196	30,560	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	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,951	309,409	36,464	378,225	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	1,300	3,098	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	724	964	13,417	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,951	311,433	40,526	391,642	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	753					8.00
9.00	00900	HOUSEKEEPING	0	96,252				9.00
10.00	01000	DIETARY	0	4,255	69,720			10.00
11.00	01100	CAFETERIA	0	7,299	0	118,174		11.00
13.00	01300	NURSING ADMINISTRATION	0	993	0	13,784	52,989	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,265	0	0	0	14.00
15.00	01500	PHARMACY	0	3,052	0	5,879	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	753	19,346	69,720	22,118	22,355	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,359	0	6,278	3,189	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,332	0	14,352	0	54.00
60.00	06000	LABORATORY	0	6,327	0	10,361	0	60.00
66.00	06600	PHYSICAL THERAPY	0	4,674	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,049	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,119	0	1,182	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,339	0	982	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	4,367	0	15,196	6	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	7,975	0	28,042	27,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	753	92,751	69,720	118,174	52,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	3,501	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	753	96,252	69,720	118,174	52,989	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,503					14.00
15.00	01500	PHARMACY	523	69,675				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,893	890	0	460,059	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,302	205	0	288,947	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,211	60	0	167,554	0	54.00
60.00	06000	LABORATORY	2,180	0	0	134,805	0	60.00
66.00	06600	PHYSICAL THERAPY	1,216	0	0	85,050	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	35,941	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	20,672	0	68.00
69.00	06900	ELECTROCARDIOLOGY	988	0	0	55,734	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,806	0	0	6,504	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,393	0	0	2,681	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,041	0	49,387	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	21,624	0	23,711	0	73.01
76.00	03160	CARDIOPULMONARY	1,674	33	0	105,451	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	23,317	1,822	0	264,667	0	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,503	69,675	0	1,701,163	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	0	0	63,527	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	55,054	0	194.00
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)	61,503	69,675	0	1,819,744	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - MOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	460,059		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	288,947		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,554		54.00
60.00	06000	LABORATORY	134,805		60.00
66.00	06600	PHYSICAL THERAPY	85,050		66.00
67.00	06700	OCCUPATIONAL THERAPY	35,941		67.00
68.00	06800	SPEECH PATHOLOGY	20,672		68.00
69.00	06900	ELECTROCARDIOLOGY	55,734		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,504		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,681		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,387		73.00
73.01	07301	ONCOLOGY DRUGS	23,711		73.01
76.00	03160	CARDIOPULMONARY	105,451		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	264,667		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,701,163		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.02	19202	MOB	63,527		192.02
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	LEASED SPACE	55,054		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,819,744		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - MOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	113,185					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	106,125				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB	0	0	7,060			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	419	419	0	6,470,620		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,724	18,724	0	747,102	-6,296,038	5.00
7.00	00700	OPERATION OF PLANT	1,679	1,679	0	406,642	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	21,174	21,174	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,732	3,732	0	248,855	0	9.00
10.00	01000	DIETARY	2,670	2,670	0	51,058	0	10.00
11.00	01100	CAFETERIA	4,580	4,580	0	87,570	0	11.00
13.00	01300	NURSING ADMINISTRATION	623	623	0	816,986	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,049	2,049	0	0	0	14.00
15.00	01500	PHARMACY	1,915	1,915	0	380,630	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,140	12,140	0	947,509	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,265	10,265	0	253,194	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,228	5,228	0	672,484	0	54.00
60.00	06000	LABORATORY	3,970	3,970	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,933	2,933	0	262	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,286	1,286	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	702	702	0	69,986	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,095	2,095	0	42,558	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	2,740	2,740	0	664,901	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,004	5,004	0	1,080,883	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	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,928	103,928	0	6,470,620	-6,296,038	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	7,060	0	7,060	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	2,197	2,197	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,021	1,745,593	58,130	1,529,218		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.141547	16.448462	8.233711	0.236333		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				6,951		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001074		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: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,676,334					5.00
7.00	00700	OPERATION OF PLANT	615,843	92,363				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,564,128	21,174	64,129			7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	7,060		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	37,914	0	0	0	1,561	8.00
9.00	00900	HOUSEKEEPING	485,352	3,732	3,732	0	0	9.00
10.00	01000	DIETARY	183,067	2,670	2,670	0	0	10.00
11.00	01100	CAFETERIA	242,534	4,580	4,580	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,153,851	623	623	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	545,310	2,049	2,049	0	0	14.00
15.00	01500	PHARMACY	780,600	1,915	1,915	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,565,303	12,140	12,140	0	1,561	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	848,329	10,265	10,265	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,002,821	5,228	5,228	0	0	54.00
60.00	06000	LABORATORY	1,212,517	3,970	3,970	0	0	60.00
66.00	06600	PHYSICAL THERAPY	568,960	2,933	2,933	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,368	1,286	1,286	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	103,445	702	702	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	96,092	2,095	2,095	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,129	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,479	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,789	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	105,039	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,010,228	2,740	2,740	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,976,346	5,004	5,004	0	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	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,574,444	83,106	61,932	0	1,561	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	65,442	7,060	0	7,060	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	36,448	2,197	2,197	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,296,038	863,182	2,390,205	0	53,141	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.401627	9.345539	37.271827	0.000000	34.042921	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	311,433	40,526	391,642	0	753	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.019866	0.438769	6.107097	0.000000	0.482383	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: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	60,397					9.00
10.00	01000	DIETARY	2,670	1,561				10.00
11.00	01100	CAFETERIA	4,580	0	7,699			11.00
13.00	01300	NURSING ADMINISTRATION	623	0	898	57,848		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,049	0	0	0	372,130	14.00
15.00	01500	PHARMACY	1,915	0	383	0	3,162	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,140	1,561	1,441	24,405	71,959	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,265	0	409	3,481	50,235	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,228	0	935	0	19,431	54.00
60.00	06000	LABORATORY	3,970	0	675	0	13,190	60.00
66.00	06600	PHYSICAL THERAPY	2,933	0	0	0	7,357	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,286	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	702	0	77	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,095	0	64	0	5,975	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	35,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14,479	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	2,740	0	990	7	10,129	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,004	0	1,827	29,955	141,084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,200	1,561	7,699	57,848	372,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	2,197	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	854,258	418,826	618,230	1,727,232	888,821	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.144047	268.306214	80.300039	29.858111	2.388469	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	96,252	69,720	118,174	52,989	61,503	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.593655	44.663677	15.349266	0.916004	0.165273	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: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:37 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB				1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - MOB				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	338,448			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	4,324	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	994	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	292	0		54.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,789	0		73.00
73.01	07301	ONCOLOGY DRUGS	105,039	0		73.01
76.00	03160	CARDIOPULMONARY	161	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	8,849	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		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338,448	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	LEASED SPACE	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,248,776	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.689713	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	69,675	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.205866	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | 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	4,435,807		4,435,807	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,073,189		2,073,189	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,845,809		1,845,809	0	0	54.00
60.00	06000	LABORATORY	2,026,427		2,026,427	0	0	60.00
66.00	06600	PHYSICAL THERAPY	993,254	0	993,254	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	370,193	0	370,193	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	193,829	0	193,829	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	281,390		281,390	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,143		133,143	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,877		54,877	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,113,930		1,113,930	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	534,789		534,789	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,686,943		1,686,943	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	5,886,508		5,886,508	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,146,202		1,146,202		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	22,776,290	0	22,776,290	0	0	200.00
201.00		Less Observation Beds	1,146,202		1,146,202		0	201.00
202.00		Total (see instructions)	21,630,088	0	21,630,088	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	2,973,785		2,973,785			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,575	3,379,061	3,444,636	0.601860	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,790	6,364,508	6,656,298	0.277303	0.000000	54.00
60.00	06000	LABORATORY	464,067	3,047,457	3,511,524	0.577079	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	473,193	1,762,448	2,235,641	0.444282	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,140	687,495	988,635	0.374449	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	110,925	253,264	364,189	0.532221	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	736,786	736,786	0.381916	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,097	176,508	177,605	0.749658	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	157,925	157,925	0.347488	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	833,482	1,401,415	2,234,897	0.498426	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	785,357	785,357	0.680950	0.000000	73.01
76.00	03160	CARDIOPULMONARY	509,579	2,982,759	3,492,338	0.483041	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	296,285	17,169,197	17,465,482	0.337037	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,229,115	2,229,115	0.514196	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	6,320,918	41,133,295	47,454,213			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,320,918	41,133,295	47,454,213			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY DRUGS	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,435,807		4,435,807	0	4,435,807	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,073,189		2,073,189	0	2,073,189	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,845,809		1,845,809	0	1,845,809	54.00
60.00	06000	LABORATORY	2,026,427		2,026,427	0	2,026,427	60.00
66.00	06600	PHYSICAL THERAPY	993,254	0	993,254	0	993,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	370,193	0	370,193	0	370,193	67.00
68.00	06800	SPEECH PATHOLOGY	193,829	0	193,829	0	193,829	68.00
69.00	06900	ELECTROCARDIOLOGY	281,390		281,390	0	281,390	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,143		133,143	0	133,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,877		54,877	0	54,877	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,113,930		1,113,930	0	1,113,930	73.00
73.01	07301	ONCOLOGY DRUGS	534,789		534,789	0	534,789	73.01
76.00	03160	CARDIOPULMONARY	1,686,943		1,686,943	0	1,686,943	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	5,886,508		5,886,508	0	5,886,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,146,202		1,146,202		1,146,202	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	22,776,290	0	22,776,290	0	22,776,290	200.00
201.00		Less Observation Beds	1,146,202		1,146,202		1,146,202	201.00
202.00		Total (see instructions)	21,630,088	0	21,630,088	0	21,630,088	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:37 am

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	2,973,785		2,973,785			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,575	3,379,061	3,444,636	0.601860	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,790	6,364,508	6,656,298	0.277303	0.000000	54.00
60.00	06000	LABORATORY	464,067	3,047,457	3,511,524	0.577079	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	473,193	1,762,448	2,235,641	0.444282	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,140	687,495	988,635	0.374449	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	110,925	253,264	364,189	0.532221	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	736,786	736,786	0.381916	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,097	176,508	177,605	0.749658	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	157,925	157,925	0.347488	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	833,482	1,401,415	2,234,897	0.498426	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	785,357	785,357	0.680950	0.000000	73.01
76.00	03160	CARDIOPULMONARY	509,579	2,982,759	3,492,338	0.483041	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	296,285	17,169,197	17,465,482	0.337037	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,229,115	2,229,115	0.514196	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	6,320,918	41,133,295	47,454,213			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,320,918	41,133,295	47,454,213			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:37 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY DRUGS	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		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	288,947	3,444,636	0.083883	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,554	6,656,298	0.025172	124,386	3,131	54.00
60.00	06000	LABORATORY	134,805	3,511,524	0.038389	216,044	8,294	60.00
66.00	06600	PHYSICAL THERAPY	85,050	2,235,641	0.038043	122,043	4,643	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,941	988,635	0.036354	49,318	1,793	67.00
68.00	06800	SPEECH PATHOLOGY	20,672	364,189	0.056762	80,958	4,595	68.00
69.00	06900	ELECTROCARDIOLOGY	55,734	736,786	0.075645	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,504	177,605	0.036621	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,681	157,925	0.016976	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,387	2,234,897	0.022098	429,374	9,488	73.00
73.01	07301	ONCOLOGY DRUGS	23,711	785,357	0.030191	0	0	73.01
76.00	03160	CARDIOPULMONARY	105,451	3,492,338	0.030195	311,673	9,411	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	264,667	17,465,482	0.015154	10,303	156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	118,878	2,229,115	0.053330	0	0	92.00
200.00		Total (lines 50 through 199)	1,359,982	44,480,428		1,344,099	41,511	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		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	3,444,636	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,656,298	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,511,524	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,235,641	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	988,635	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	364,189	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	736,786	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	177,605	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	157,925	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,234,897	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	785,357	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	3,492,338	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	17,465,482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,229,115	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	44,480,428		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	124,386	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	216,044	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	122,043	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	49,318	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	80,958	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	429,374	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	311,673	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	10,303	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)		1,344,099	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		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	0.601860	0	905,654	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.277303	0	1,582,642	0	0	54.00
60.00	06000	LABORATORY	0.577079	0	769,556	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.444282	0	495,431	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374449	0	216,103	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.532221	0	35,408	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.381916	0	202,638	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.749658	0	9,940	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347488	0	56,893	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.498426	0	328,035	1,052	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.680950	0	534,247	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.483041	0	1,302,666	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.337037	0	3,916,135	680	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514196	0	1,093,128	0	0	92.00
200.00		Subtotal (see instructions)		0	11,448,476	1,732	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	11,448,476	1,732	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		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	545,077	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	438,871	0		54.00
60.00	06000	LABORATORY	444,095	0		60.00
66.00	06600	PHYSICAL THERAPY	220,111	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	80,920	0		67.00
68.00	06800	SPEECH PATHOLOGY	18,845	0		68.00
69.00	06900	ELECTROCARDIOLOGY	77,391	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,452	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,770	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,501	524		73.00
73.01	07301	ONCOLOGY DRUGS	363,795	0		73.01
76.00	03160	CARDIOPULMONARY	629,241	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,319,882	229		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	562,082	0		92.00
200.00		Subtotal (see instructions)	4,891,033	753		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,891,033	753		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1316 | Component CCN: 15-Z316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Swing Beds - SNF | Cost

		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	0.601860	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.277303	0	0	0	0	54.00
60.00	06000	LABORATORY	0.577079	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.444282	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374449	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.532221	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.381916	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.749658	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347488	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.498426	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.680950	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.483041	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.337037	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514196	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1316 | Component CCN: 15-Z316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Swing Beds - SNF | Cost

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY DRUGS	0	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:37 am

Title XIX | Hospital | Cost

		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	0.601860	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.277303	0	0	0	0	54.00
60.00	06000	LABORATORY	0.577079	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.444282	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374449	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.532221	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.381916	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.749658	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347488	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.498426	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.680950	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.483041	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.337037	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514196	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:37 am

Title XIX | Hospital | Cost

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY DRUGS	0	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,047	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,689	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)	1,203	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	183	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	175	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)	707	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)	183	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,435,807	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)	20,808	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)	452,403	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,983,404	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)	3,983,404	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)	2,358.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,667,417	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)	1,667,417	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | 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						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)	642,978	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,310,395	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)	431,595	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)	431,595	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)	486	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,358.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,146,202	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | 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	460,059	4,435,807	0.103715	1,146,202	118,878	90.00
91.00	Nursing School cost	0	4,435,807	0.000000	1,146,202	0	91.00
92.00	Allied health cost	0	4,435,807	0.000000	1,146,202	0	92.00
93.00	All other Medical Education	0	4,435,807	0.000000	1,146,202	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:37 am

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)	2,047	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,689	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)	1,203	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	183	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	175	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,435,807	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)	20,808	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)	452,403	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,983,404	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)	3,983,404	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)	2,358.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,717	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,717	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:37 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	9,139	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	13,856	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)	486	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,358.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,146,202	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:37 am

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	460,059	4,435,807	0.103715	1,146,202	118,878	90.00
91.00	Nursing School cost	0	4,435,807	0.000000	1,146,202	0	91.00
92.00	Allied health cost	0	4,435,807	0.000000	1,146,202	0	92.00
93.00	All other Medical Education	0	4,435,807	0.000000	1,146,202	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | 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		1,476,235		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.601860	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.277303	124,386	34,493	54.00
60.00	06000	LABORATORY	0.577079	216,044	124,674	60.00
66.00	06600	PHYSICAL THERAPY	0.444282	122,043	54,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374449	49,318	18,467	67.00
68.00	06800	SPEECH PATHOLOGY	0.532221	80,958	43,088	68.00
69.00	06900	ELECTROCARDIOLOGY	0.381916	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.749658	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347488	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.498426	429,374	214,011	73.00
73.01	07301	ONCOLOGY DRUGS	0.680950	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.483041	311,673	150,551	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.337037	10,303	3,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514196	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,344,099	642,978	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)		1,344,099		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3

Component CCN: 15-Z316 | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.601860	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.277303	7,654	2,122	54.00
60.00	06000	LABORATORY	0.577079	23,445	13,530	60.00
66.00	06600	PHYSICAL THERAPY	0.444282	137,811	61,227	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374449	112,150	41,994	67.00
68.00	06800	SPEECH PATHOLOGY	0.532221	2,696	1,435	68.00
69.00	06900	ELECTROCARDIOLOGY	0.381916	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.749658	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347488	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.498426	50,055	24,949	73.00
73.01	07301	ONCOLOGY DRUGS	0.680950	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.483041	10,655	5,147	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.337037	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514196	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		344,466	150,404	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)		344,466		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:37 am

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		14,840		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.601860	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.277303	2,373	658	54.00
60.00	06000	LABORATORY	0.577079	2,950	1,702	60.00
66.00	06600	PHYSICAL THERAPY	0.444282	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374449	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.532221	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.381916	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.749658	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347488	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.498426	9,264	4,617	73.00
73.01	07301	ONCOLOGY DRUGS	0.680950	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.483041	2,044	987	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.337037	3,486	1,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514196	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		20,117	9,139	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)		20,117		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 8:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,891,786	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,891,786	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,940,704	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	22,561	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,110,077	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)	2,808,066	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)	2,808,066	30.00
31.00	Primary payer payments	5,581	31.00
32.00	Subtotal (line 30 minus line 31)	2,802,485	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)	474,448	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	308,391	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	474,660	36.00
37.00	Subtotal (see instructions)	3,110,876	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,110,876	40.00
40.01	Sequestration adjustment (see instructions)	62,218	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	2,656,924	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)	391,734	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	176,955	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: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Hospital | Cost

		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		1,955,659		2,656,924	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)		1,955,659		2,656,924	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		129,542		391,734	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,085,201		3,048,658	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: 15-1316 | Component CCN: 15-Z316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/29/2020 8:37 am

Title XVIII | Swing Beds - SNF | Cost

		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		343,707		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)		343,707		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		232,356		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		576,063		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: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/29/2020 8:37 am
	Title XVIII	Hospital	Cost

			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 - SWING BEDS	Provider CCN: 15-1316 Component CCN: 15-Z316	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2 Date/Time Prepared: 6/29/2020 8:37 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	435,911	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	151,908	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	183	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	587,819	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	587,819	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	587,819	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	587,819	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	587,819	0	19.00
19.01	Sequestration adjustment (see instructions)	11,756	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	343,707	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	232,356	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	21,113	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 8:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,310,395	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,310,395	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,333,499	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,333,499	19.00
20.00	Deductibles (exclude professional component)	214,100	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,119,399	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,119,399	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,857	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	8,357	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,857	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,127,756	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,127,756	30.00
30.01	Sequestration adjustment (see instructions)	42,555	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,955,659	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	129,542	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	83,812	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/29/2020 8:37 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-81,071	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	1,710,782	0	0	0	4.00
5.00	Other receivable	2,598,235	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	204,374	0	0	0	7.00
8.00	Prepaid expenses	187,271	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,619,591	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	951,048	0	0	0	12.00
13.00	Land improvements	16,117	0	0	0	13.00
14.00	Accumulated depreciation	-1,343	0	0	0	14.00
15.00	Buildings	35,315	0	0	0	15.00
16.00	Accumulated depreciation	-5,585	0	0	0	16.00
17.00	Leasehold improvements	496,826	0	0	0	17.00
18.00	Accumulated depreciation	-278,646	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	5,762,595	0	0	0	23.00
24.00	Accumulated depreciation	-2,339,952	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)	4,636,375	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	6,004,063	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,004,063	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,260,029	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	21,813,697	0	0	0	37.00
38.00	Salaries, wages, and fees payable	647,554	0	0	0	38.00
39.00	Payroll taxes payable	32,697	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	1,897,744	0	0	0	43.00
44.00	Other current liabilities	457,687	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,849,379	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	82,399	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	82,399	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,931,778	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-9,671,749				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)	-9,671,749	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,260,029	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/29/2020 8:37 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-11,853,684		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,317,706				2.00
3.00	Total (sum of line 1 and line 2)		-15,171,390		0		3.00
4.00	NET INTERCOMPANY TRANSACTIONS	5,499,640		0		0	4.00
5.00	ROUNDING	1		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)		5,499,641		0		10.00
11.00	Subtotal (line 3 plus line 10)		-9,671,749		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-9,671,749		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	NET INTERCOMPANY TRANSACTIONS		0			4.00
5.00	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1316 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/29/2020 8:37 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,651,351		2,651,351	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	322,434		322,434	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)	2,973,785		2,973,785	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,973,785		2,973,785	17.00
18.00	Ancillary services	3,050,848	21,734,983	24,785,831	18.00
19.00	Outpatient services	296,285	19,398,312	19,694,597	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				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,320,918	41,133,295	47,454,213	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,024,285		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)		23,024,285		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 6/29/2020 8:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	47,454,213	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,599,611	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,854,602	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,024,285	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,169,683	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	MISCELLANEOUS INCOME	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-3,169,683	26.00
27.00	MISCELLANEOUS INCOME	148,023	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	148,023	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,317,706	29.00