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: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/27/2020 4:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/27/2020 Time: 4:01 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHNSON MEMORIAL HOSPITAL (15-0001) 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) ADAM PUTVIN
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	52,632	-11,670	0	-296,272	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
200.00	Total	0	52,632	-11,669	0	-296,272	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 4:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1125 WEST JEFFERSON STREET	PO Box:			1.00
2.00	City: FRANKLIN	State: IN	Zip Code: 46131-	County: JOHNSON	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	JOHNSON MEMORIAL HOSPITAL	150001	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	JOHNSON MEMORIAL HOME HEALTH	157510	26900		07/01/1997	N	P	N	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)	9		21.00

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

		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.	180	1,010	0	0	342	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

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

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

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 4:01 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 4:01 pm

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 4:01 pm

		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	153,977	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 4:01 pm

		1.00	2.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 4:01 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 8/27/2020 4:01 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		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)	Y	08/18/2020	Y	08/18/2020
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)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 4:01 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 4:01 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	43	15,695	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		43	15,695	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		49	17,885	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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)		49				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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,122	134	5,296			1.00
2.00	HMO and other (see instructions)	721	1,314				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,122	134	5,296			7.00
8.00	INTENSIVE CARE UNIT	241	0	503			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		42	736			13.00
14.00	Total (see instructions)	2,363	176	6,535	0.00	555.54	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,793	0	5,003	0.00	8.28	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			50			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	563.82	27.00
28.00	Observation Bed Days		0	885			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	42	105			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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	683	49	2,011	1.00
2.00	HMO and other (see instructions)			190	362		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	683	49	2,011	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 8/27/2020 4:01 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	42,012,440	-131,929	41,880,511	1,172,754.00	35.71	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,295,853	0	1,295,853	13,250.00	97.80	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		617,591	0	617,591	17,931.00	34.44	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		13,195,226	-31,171	13,164,055	223,030.00	59.02	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,900,678	0	1,900,678	24,261.00	78.34	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		199,000	0	199,000	951.00	209.25	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,623,467	0	7,623,467			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,454,901	0	2,454,901			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		163,068	0	163,068			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 8/27/2020 4:01 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,301,548	0	3,301,548	154,667.00	21.35	26.00
27.00	Administrative & General	5.00	2,256,321	-69,587	2,186,734	58,311.00	37.50	27.00
28.00	Administrative & General under contract (see inst.)		660,564	0	660,564	5,392.00	122.51	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	660,564	0	660,564	31,120.00	21.23	30.00
31.00	Laundry & Linen Service	8.00	100,817	0	100,817	6,911.00	14.59	31.00
32.00	Housekeeping	9.00	641,899	0	641,899	46,451.00	13.82	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	730,352	-489,681	240,671	14,238.00	16.90	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	489,681	489,681	28,969.00	16.90	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,239,863	0	1,239,863	23,061.00	53.76	38.00
39.00	Central Services and Supply	14.00	76,893	0	76,893	4,396.00	17.49	39.00
40.00	Pharmacy	15.00	564,052	0	564,052	14,685.00	38.41	40.00
41.00	Medical Records & Medical Records Library	16.00	490,739	0	490,739	24,244.00	20.24	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 8/27/2020 4:01 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		40,759,560	-131,929	40,627,631	1,146,965.00	35.42	1.00
2.00	Excluded area salaries (see instructions)		13,195,226	-31,171	13,164,055	223,030.00	59.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)		27,564,334	-100,758	27,463,576	923,935.00	29.72	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,099,678	0	2,099,678	25,212.00	83.28	4.00
5.00	Subtotal wage-related costs (see inst.)		7,623,467	0	7,623,467	0.00	27.76	5.00
6.00	Total (sum of lines 3 thru 5)		37,287,479	-100,758	37,186,721	949,147.00	39.18	6.00
7.00	Total overhead cost (see instructions)		10,723,612	-69,587	10,654,025	412,445.00	25.83	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part IV Date/Time Prepared: 8/27/2020 4:01 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	934,063	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,135,927	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,143	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	167,621	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	234,668	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,695,776	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,326	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	28,912	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,241,436	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part V Date/Time Prepared: 8/27/2020 4:01 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,900,678	10,241,436	1.00
2.00	Hospital	1,900,678	10,241,436	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0001 | Component CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-4 | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	132.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	1.53	0.00	1.53	3.00
4.00	Director(s) and Assistant Director(s)			0.13	0.00	0.13	4.00
5.00	Other Administrative Personnel			0.40	0.00	0.40	5.00
6.00	Direct Nursing Service			2.42	0.00	2.42	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.25	0.00	1.25	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.97	0.00	0.97	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.79	0.00	0.79	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			18020			20.00
20.01				26900			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,315	0	24	27	1,366	21.00
22.00	Skilled Nursing Visit Charges	315,600	0	5,760	6,480	327,840	22.00
23.00	Physical Therapy Visits	802	0	0	27	829	23.00
24.00	Physical Therapy Visit Charges	207,480	0	0	7,020	214,500	24.00
25.00	Occupational Therapy Visits	577	0	0	21	598	25.00
26.00	Occupational Therapy Visit Charges	150,020	0	0	5,460	155,480	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	1,040	0	0	0	1,040	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,694	0	24	75	2,793	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	674,140	0	5,760	18,960	698,860	35.00
36.00	Total Number of Episodes (standard/non outlier)	157		11	5	173	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	9,207	0	160	1,449	10,816	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 8/27/2020 4:01 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.249953	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,920,106	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	32,826,549	6.00
7.00	Medicaid cost (line 1 times line 6)	8,205,094	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)	6,284,988	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,284,988	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)	3,253,440	3,579,253	6,832,693	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	813,207	3,579,253	4,392,460	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)	813,207	3,579,253	4,392,460	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)	4,648,623	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	79,049	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	121,614	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,527,009	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,174,104	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,566,564	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,851,552	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		300,970	300,970	0	300,970	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,413,837	4,413,837	0	4,413,837	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	320,524	7,971,473	8,291,997	69,587	8,361,584	4.00
4.01	00401	COMMUNICATIONS	87,923	275,726	363,649	-55	363,594	4.01
4.02	00402	DATA PROCESSING	770,890	2,237,254	3,008,144	-13	3,008,131	4.02
4.03	00403	MATERIALS MANAGEMENT	336,396	35,835	372,231	-2,161	370,070	4.03
4.04	00404	ADMITTING	773,909	6,664	780,573	-344	780,229	4.04
4.05	00405	PATIENT ACCOUNTING	1,011,906	722,495	1,734,401	0	1,734,401	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	2,256,321	6,087,513	8,343,834	-70,283	8,273,551	5.00
7.00	00700	OPERATION OF PLANT	660,564	2,043,903	2,704,467	-133	2,704,334	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100,817	90,540	191,357	-890	190,467	8.00
9.00	00900	HOUSEKEEPING	641,899	102,242	744,141	-7,936	736,205	9.00
10.00	01000	DIETARY	730,352	354,316	1,084,668	-727,395	357,273	10.00
11.00	01100	CAFETERIA	0	0	0	727,240	727,240	11.00
13.00	01300	NURSING ADMINISTRATION	1,239,863	198,008	1,437,871	-325	1,437,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	76,893	129,700	206,593	-51,329	155,264	14.00
15.00	01500	PHARMACY	564,052	5,028,592	5,592,644	-4,110,769	1,481,875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	490,739	70,368	561,107	-51	561,056	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,406,949	821,483	5,228,432	-579,587	4,648,845	30.00
31.00	03100	INTENSIVE CARE UNIT	1,119,267	347,294	1,466,561	-42,303	1,424,258	31.00
41.00	04100	SUBPROVIDER - IRF	0	137	137	0	137	41.00
43.00	04300	NURSERY	0	0	0	424,963	424,963	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,886,597	524,258	2,410,855	-288,514	2,122,341	50.00
53.00	05300	ANESTHESIOLOGY	0	12,180	12,180	54,961	67,141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,997,127	1,133,048	3,130,175	-93,370	3,036,805	54.00
60.00	06000	LABORATORY	1,941,363	2,524,572	4,465,935	-200,067	4,265,868	60.00
65.00	06500	RESPIRATORY THERAPY	1,039,211	208,360	1,247,571	-58,991	1,188,580	65.00
66.00	06600	PHYSICAL THERAPY	743,133	29,594	772,727	-16,392	756,335	66.00
67.00	06700	OCCUPATIONAL THERAPY	266,810	0	266,810	0	266,810	67.00
68.00	06800	SPEECH PATHOLOGY	138,624	62	138,686	0	138,686	68.00
69.00	06900	ELECTROCARDIOLOGY	294,100	99,319	393,419	-6,873	386,546	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,682	6,333	13,015	-259	12,756	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,894,053	3,894,053	-1,195,167	2,698,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,690,246	2,690,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,626,457	4,626,457	73.00
76.00	03020	ONCOLOGY	304,831	196,484	501,315	-8,657	492,658	76.00
76.97	07697	CARDIAC REHABILITATION	135,499	167,552	303,051	-5,445	297,606	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	699,565	2,030,806	2,730,371	-460,901	2,269,470	90.00
91.00	09100	EMERGENCY	3,774,408	970,546	4,744,954	-71,831	4,673,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	620,608	112,928	733,536	-11,490	722,046	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,437,822	43,148,445	72,586,267	581,923	73,168,190	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,611	28,960	79,571	-167	79,404	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,374,268	4,128,341	16,502,609	-576,256	15,926,353	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	73,794	6,173	79,967	-5,500	74,467	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	1,836	141	1,977	0	1,977	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	26,109	47,016	73,125	0	73,125	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,000	0	48,000	0	48,000	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	42,012,440	47,359,076	89,371,516	0	89,371,516	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-3,853,632	-3,552,662		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,413,837		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-85,304	8,276,280		4.00
4.01	00401	COMMUNICATIONS	-21,347	342,247		4.01
4.02	00402	DATA PROCESSING	0	3,008,131		4.02
4.03	00403	MATERIALS MANAGEMENT	0	370,070		4.03
4.04	00404	ADMITTING	0	780,229		4.04
4.05	00405	PATIENT ACCOUNTING	-162	1,734,239		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-446,391	7,827,160		5.00
7.00	00700	OPERATION OF PLANT	-36,731	2,667,603		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	190,467		8.00
9.00	00900	HOUSEKEEPING	0	736,205		9.00
10.00	01000	DIETARY	0	357,273		10.00
11.00	01100	CAFETERIA	-308,993	418,247		11.00
13.00	01300	NURSING ADMINISTRATION	-9	1,437,537		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	155,264		14.00
15.00	01500	PHARMACY	-28	1,481,847		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-37,727	523,329		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,736,797	2,912,048		30.00
31.00	03100	INTENSIVE CARE UNIT	-252,385	1,171,873		31.00
41.00	04100	SUBPROVIDER - IRF	0	137		41.00
43.00	04300	NURSERY	0	424,963		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,122,341		50.00
53.00	05300	ANESTHESIOLOGY	0	67,141		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,036,805		54.00
60.00	06000	LABORATORY	-5,098	4,260,770		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,188,580		65.00
66.00	06600	PHYSICAL THERAPY	-1,059	755,276		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	266,810		67.00
68.00	06800	SPEECH PATHOLOGY	0	138,686		68.00
69.00	06900	ELECTROCARDIOLOGY	-28,953	357,593		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,756		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,698,886		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,690,246		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,626,457		73.00
76.00	03020	ONCOLOGY	-105,414	387,244		76.00
76.97	07697	CARDIAC REHABILITATION	-41,500	256,106		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-600,079	1,669,391		90.00
91.00	09100	EMERGENCY	-2,528,704	2,144,419		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	722,046		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,090,313	63,077,877		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	79,404		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,926,353		192.00
192.01	19201	SOUTH CLINIC	0	0		192.01
192.02	19202	WEST CLINIC	0	0		192.02
192.03	19203	DIABETES CENTER	0	74,467		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	1,977		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0		193.03
194.00	07950	PARTNERSHIP HFC	0	73,125		194.00
194.01	07951	TRAFALGAR CLINIC	0	0		194.01
194.02	07952	EDINBURGH	0	0		194.02
194.03	07953	JAIL	0	48,000		194.03
194.04	07954	ATHLETIC TRAINERS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,090,313	79,281,203		200.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/27/2020 4:01 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - NURSERY RECLASS				
1.00	NURSERY	43.00	390,245	34,718	1.00
	TOTALS		390,245	34,718	
	B - IMPLANTABLE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,690,246	1.00
	TOTALS		0	2,690,246	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	489,681	237,559	1.00
	TOTALS		489,681	237,559	
	D - STD RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,171	1.00
2.00	HOME HEALTH AGENCY	101.00	0	6,415	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	19,500	3.00
4.00	PARTNERSHIP HFC	194.00	0	5,256	4.00
	TOTALS		0	62,342	
	E - EMPLOYEE WELLNESS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	69,587	1.00
	TOTALS		0	69,587	
	F - PART A RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	5,500	1.00
2.00	ANESTHESIOLOGY	53.00	0	55,000	2.00
	TOTALS		0	60,500	
	G - MEDICIAL SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,495,079	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	1,495,079	
	H - DRUGS CHARGEABLE RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,626,457	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	4,626,457	
500.00	Grand Total: Increases		879,926	9,276,488	500.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/27/2020 4:01 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	390,245	34,718	0		1.00
	TOTALS		390,245	34,718			
	B - IMPLANTABLE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,690,246	0		1.00
	TOTALS		0	2,690,246			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	489,681	237,559	0		1.00
	TOTALS		489,681	237,559			
	D - STD RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	31,171	0	0		1.00
2.00	HOME HEALTH AGENCY	101.00	6,415	0	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	19,500	0	0		3.00
4.00	PARTNERSHIP HFC	194.00	5,256	0	0		4.00
	TOTALS		62,342	0			
	E - EMPLOYEE WELLNESS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	69,587	0	0		1.00
	TOTALS		69,587	0			
	F - PART A RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	55,000	0		1.00
2.00	DIABETES CENTER	192.03	0	5,500	0		2.00
	TOTALS		0	60,500			
	G - MEDICIAL SUPPLIES RECLASS						
1.00	COMMUNICATIONS	4.01	0	55	0		1.00
2.00	DATA PROCESSING	4.02	0	13	0		2.00
3.00	MATERIALS MANAGEMENT	4.03	0	2,161	0		3.00
4.00	ADMITTING	4.04	0	344	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	238	0		5.00
6.00	OPERATION OF PLANT	7.00	0	133	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	890	0		7.00
8.00	HOUSEKEEPING	9.00	0	7,936	0		8.00
9.00	DIETARY	10.00	0	155	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	325	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	51,329	0		11.00
12.00	PHARMACY	15.00	0	4,418	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	51	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	0	158,347	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	0	41,298	0		15.00
16.00	OPERATING ROOM	50.00	0	288,323	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	39	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	86,230	0		18.00
19.00	LABORATORY	60.00	0	200,018	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	44,635	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	16,283	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	6,856	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	259	0		23.00
24.00	ONCOLOGY	76.00	0	7,261	0		24.00
25.00	CARDIAC REHABILITATION	76.97	0	5,445	0		25.00
26.00	CLINIC	90.00	0	379,359	0		26.00
27.00	EMERGENCY	91.00	0	70,869	0		27.00
28.00	HOME HEALTH AGENCY	101.00	0	11,490	0		28.00
29.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	167	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	110,152	0		30.00
	TOTALS		0	1,495,079			
	H - DRUGS CHARGEABLE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	458	0		1.00
2.00	PHARMACY	15.00	0	4,106,351	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,777	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	1,005	0		4.00
5.00	OPERATING ROOM	50.00	0	191	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,140	0		6.00
7.00	LABORATORY	60.00	0	49	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	14,356	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	109	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	17	0		10.00
11.00	ONCOLOGY	76.00	0	1,396	0		11.00
12.00	CLINIC	90.00	0	81,542	0		12.00
13.00	EMERGENCY	91.00	0	962	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	411,104	0		14.00
	TOTALS		0	4,626,457			
500.00	Grand Total: Decreases		1,011,855	9,144,559			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,743,426	0	0	0	0	1.00
2.00	Land Improvements	2,889,286	0	0	0	8,467	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	69,624,719	39,119	0	39,119	1,140,790	4.00
5.00	Fixed Equipment	13,061,221	47,187	0	47,187	0	5.00
6.00	Movable Equipment	53,258,520	1,347,231	0	1,347,231	783,153	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	143,577,172	1,433,537	0	1,433,537	1,932,410	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	143,577,172	1,433,537	0	1,433,537	1,932,410	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,743,426	0	1.00
2.00	Land Improvements	2,880,819	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	68,523,048	0	4.00
5.00	Fixed Equipment	13,108,408	0	5.00
6.00	Movable Equipment	53,822,598	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	143,078,299	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	143,078,299	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 8/27/2020 4:01 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	300,970	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,413,837	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,714,807	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	NEW CAP REL COSTS-BLDG & FIXT	0	300,970		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,413,837		2.00
3.00	Total (sum of lines 1-2)	0	4,714,807		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 8/27/2020 4:01 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	143,078,299	0	143,078,299	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	143,078,299	0	143,078,299	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	-3,552,662	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,413,837	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	861,175	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	-3,552,662	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,413,837	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	861,175	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/27/2020 4:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	-5,294,891			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/27/2020 4:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CAFETERIA CANTEEN VENDING REVENUE	B	-308,993	CAFETERIA	11.00	0	33.00
33.01	CAFETERIA CANTEEN VENDING REVENUE	B	-162	PATIENT ACCOUNTING	4.05	0	33.01
33.02	CAFETERIA CANTEEN VENDING REVENUE	B	-339	OPERATION OF PLANT	7.00	0	33.02
33.03	MISC OTHER REVENUE	B	-15,524	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC OTHER REVENUE	B	-28	PHARMACY	15.00	0	33.04
33.05	MISC OTHER REVENUE	B	-37,727	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06	MISC OTHER REVENUE	B	-4,932	LABORATORY	60.00	0	33.06
33.07	CABLE SERVICES	A	-28,676	OPERATION OF PLANT	7.00	0	33.07
33.08	TELEPHONE SERVICES	A	-1,177	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	TELEPHONE SERVICES	A	-17,791	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	COMMUNICATIONS	A	-21,347	COMMUNICATIONS	4.01	0	33.10
33.11	ADVERTISING EXP - A&G	A	-377,802	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ADVERTISING EXP - NURSING ADMIN	A	-9	NURSING ADMINISTRATION	13.00	0	33.12
33.13	ADVERTISING EXP - LABORATORY	A	-166	LABORATORY	60.00	0	33.13
33.14	DAYCARE	B	-741	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	LOBBYING EXPENSE - IHHA	A	-1,969	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PROF - BUILDING	A	-23,407	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	PROF - BUILDING	A	-7,716	OPERATION OF PLANT	7.00	0	33.17
33.18	1993 AHA LIFE	A	-84,563	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	HAF EXPENSE	A	-3,852,455	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.19
33.20	INTEREST EXPENSE	A	-4,357	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	LOBBYING EXPENSE-AHA	A	-5,541	ADMINISTRATIVE & GENERAL	5.00	0	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,090,313				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 8/27/2020 4:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,736,797	1,736,797	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	252,385	252,385	0	0	0	2.00
3.00	60.00	LABORATORY	137,925	0	137,925	211,500	1,975	3.00
4.00	66.00	PHYSICAL THERAPY	1,059	1,059	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	59,051	0	59,051	211,500	296	5.00
6.00	76.00	ONCOLOGY	132,258	0	132,258	211,500	264	6.00
7.00	76.97	CARDIAC REHABILITATION	41,500	41,500	0	0	0	7.00
8.00	90.00	CLINIC	600,079	600,079	0	0	0	8.00
9.00	91.00	EMERGENCY	2,528,704	2,528,704	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,489,758	5,160,524	329,234		2,535	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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	200,823	10,041	0	0	0	3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	30,098	1,505	0	0	0	5.00
6.00	76.00	ONCOLOGY	26,844	1,342	0	0	0	6.00
7.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			257,765	12,888	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	1,736,797		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	252,385		2.00
3.00	60.00	LABORATORY	0	200,823	0	0		3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	1,059		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	30,098	28,953	28,953		5.00
6.00	76.00	ONCOLOGY	0	26,844	105,414	105,414		6.00
7.00	76.97	CARDIAC REHABILITATION	0	0	0	41,500		7.00
8.00	90.00	CLINIC	0	0	0	600,079		8.00
9.00	91.00	EMERGENCY	0	0	0	2,528,704		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	257,765	134,367	5,294,891		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				NEW BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-3,552,662	-3,552,662				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,413,837		4,413,837			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,276,280	0	1,979	8,278,259		4.00
4.01	00401	COMMUNICATIONS	342,247	0	0	24,922	367,169	4.01
4.02	00402	DATA PROCESSING	3,008,131	0	2,082,951	218,510	37,019	4.02
4.03	00403	MATERIALS MANAGEMENT	370,070	0	9,868	95,352	7,952	4.03
4.04	00404	ADMITTING	780,229	0	0	219,365	9,323	4.04
4.05	00405	PATIENT ACCOUNTING	1,734,239	0	17,417	286,826	24,131	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	7,827,160	0	43,717	619,832	21,114	5.00
7.00	00700	OPERATION OF PLANT	2,667,603	0	67,055	187,238	13,436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190,467	0	7,384	28,577	1,371	8.00
9.00	00900	HOUSEKEEPING	736,205	0	6,644	181,947	3,839	9.00
10.00	01000	DIETARY	357,273	0	30,923	68,218	7,129	10.00
11.00	01100	CAFETERIA	418,247	0	0	138,801	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,437,537	0	48,743	351,440	12,614	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	155,264	0	49,164	21,795	0	14.00
15.00	01500	PHARMACY	1,481,847	0	8,310	159,881	6,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	523,329	0	12,007	139,100	10,146	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,912,048	0	194,113	1,203,278	28,792	30.00
31.00	03100	INTENSIVE CARE UNIT	1,171,873	0	53,033	317,257	7,678	31.00
41.00	04100	SUBPROVIDER - IRF	137	0	0	0	0	41.00
43.00	04300	NURSERY	424,963	0	0	45,886	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,122,341	0	664,082	534,758	24,131	50.00
53.00	05300	ANESTHESIOLOGY	67,141	0	21,145	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,036,805	0	511,737	557,252	14,259	54.00
60.00	06000	LABORATORY	4,260,770	0	210,397	550,281	18,646	60.00
65.00	06500	RESPIRATORY THERAPY	1,188,580	0	23,069	294,565	4,936	65.00
66.00	06600	PHYSICAL THERAPY	755,276	0	15,047	210,642	6,855	66.00
67.00	06700	OCCUPATIONAL THERAPY	266,810	0	3,556	75,628	1,645	67.00
68.00	06800	SPEECH PATHOLOGY	138,686	0	557	39,293	1,645	68.00
69.00	06900	ELECTROCARDIOLOGY	357,593	0	50,570	83,363	11,791	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,756	0	2,755	1,894	548	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,698,886	0	20,904	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,690,246	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,626,457	0	0	0	0	73.00
76.00	03020	ONCOLOGY	387,244	0	3,223	86,405	10,146	76.00
76.97	07697	CARDIAC REHABILITATION	256,106	0	15,388	38,407	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,669,391	0	24,609	198,292	5,758	90.00
91.00	09100	EMERGENCY	2,144,419	0	46,329	1,069,860	16,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	722,046	0	97	174,094	6,307	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,077,877	0	4,246,773	8,222,959	313,696	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	79,404	0	6,649	14,346	4,113	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,926,353	0	159,606	0	44,972	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	74,467	0	809	20,917	823	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	1,977	0	0	520	1,371	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	73,125	0	0	5,911	2,194	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,000	0	0	13,606	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		-3,552,662	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	79,281,203	-3,552,662	4,413,837	8,278,259	367,169	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	
			4.02	4.03	4.04	4.05	4A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	5,346,611					4.02
4.03	00403	MATERIALS MANAGEMENT	115,768	599,010				4.03
4.04	00404	ADMITTING	187,624	577	1,197,118			4.04
4.05	00405	PATIENT ACCOUNTING	451,095	1,703	0	2,515,411		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	641,380	15,344	0	0	9,168,547	5.00
7.00	00700	OPERATION OF PLANT	89,155	406	0	0	3,024,893	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,267	131	0	0	261,197	8.00
9.00	00900	HOUSEKEEPING	0	897	0	0	929,532	9.00
10.00	01000	DIETARY	73,187	34,569	0	0	571,299	10.00
11.00	01100	CAFETERIA	0	0	0	0	557,048	11.00
13.00	01300	NURSING ADMINISTRATION	98,469	10,034	0	0	1,958,837	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,562	0	0	233,785	14.00
15.00	01500	PHARMACY	90,485	0	0	0	1,746,830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	192,946	467	0	0	877,995	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	295,408	35,867	58,434	117,685	4,845,625	30.00
31.00	03100	INTENSIVE CARE UNIT	183,632	11,038	6,412	12,913	1,763,836	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	137	41.00
43.00	04300	NURSERY	0	0	3,322	6,690	480,861	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	480,370	45,498	160,444	323,131	4,354,755	50.00
53.00	05300	ANESTHESIOLOGY	0	146	24,986	50,322	163,740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	200,930	27,678	253,559	510,795	5,113,015	54.00
60.00	06000	LABORATORY	239,520	205,701	185,456	373,505	6,044,276	60.00
65.00	06500	RESPIRATORY THERAPY	149,034	18,418	32,182	64,814	1,775,598	65.00
66.00	06600	PHYSICAL THERAPY	55,888	2,846	20,595	41,478	1,108,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,952	0	6,244	12,574	390,409	67.00
68.00	06800	SPEECH PATHOLOGY	13,307	9	1,891	3,809	199,197	68.00
69.00	06900	ELECTROCARDIOLOGY	171,656	1,449	19,714	39,703	735,839	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	48	448	902	19,351	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53,994	108,743	2,882,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	39,256	79,061	2,808,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100,600	202,607	4,929,664	73.00
76.00	03020	ONCOLOGY	63,872	5,256	4,352	8,765	569,263	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,245	3,285	6,615	321,046	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	195,608	29,566	60,579	122,004	2,305,807	90.00
91.00	09100	EMERGENCY	211,576	24,998	156,007	314,195	3,983,562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	55,888	2,006	4,839	9,745	975,022	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,314,017	483,459	1,196,599	2,410,056	65,100,683	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,872	2,192	0	0	170,576	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	940,778	113,148	0	104,310	17,289,167	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	3,992	26	519	1,045	102,598	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	3,868	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	23,952	185	0	0	105,367	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	61,606	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	-3,552,662	201.00
202.00		TOTAL (sum lines 118 through 201)	5,346,611	599,010	1,197,118	2,515,411	79,281,203	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,168,547					5.00
7.00	00700	OPERATION OF PLANT	376,484	3,401,377				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,509	38,387	332,093			8.00
9.00	00900	HOUSEKEEPING	115,691	29,812	60,132	1,135,167		9.00
10.00	01000	DIETARY	71,105	62,546	7,743	21,301	733,994	10.00
11.00	01100	CAFETERIA	69,331	66,602	0	22,682	0	11.00
13.00	01300	NURSING ADMINISTRATION	243,801	157,554	0	53,658	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,097	27,129	0	9,239	0	14.00
15.00	01500	PHARMACY	217,414	32,670	0	11,126	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,277	61,939	0	21,094	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	603,096	440,344	88,158	149,966	671,985	30.00
31.00	03100	INTENSIVE CARE UNIT	219,531	125,922	22,000	42,885	62,009	31.00
41.00	04100	SUBPROVIDER - IRF	17	0	0	0	0	41.00
43.00	04300	NURSERY	59,849	9,980	0	3,399	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	542,002	730,701	55,864	248,852	0	50.00
53.00	05300	ANESTHESIOLOGY	20,379	6,291	0	2,143	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	636,376	263,979	29,501	89,902	0	54.00
60.00	06000	LABORATORY	752,283	128,525	0	43,771	0	60.00
65.00	06500	RESPIRATORY THERAPY	220,994	5,972	0	2,034	0	65.00
66.00	06600	PHYSICAL THERAPY	137,982	101,204	7,439	34,467	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,591	21,317	0	7,260	0	67.00
68.00	06800	SPEECH PATHOLOGY	24,792	1,325	0	451	0	68.00
69.00	06900	ELECTROCARDIOLOGY	91,584	17,245	3,436	5,873	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,408	2,906	0	990	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	358,765	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	349,559	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	613,556	0	0	0	0	73.00
76.00	03020	ONCOLOGY	70,852	111,759	0	38,061	0	76.00
76.97	07697	CARDIAC REHABILITATION	39,958	40,095	0	13,655	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	286,985	183,885	1,998	62,625	0	90.00
91.00	09100	EMERGENCY	495,802	158,624	49,507	54,022	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	121,353	20,838	0	7,097	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,961,423	2,847,551	325,778	946,553	733,994	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,230	20,710	0	7,053	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,151,861	413,965	6,315	140,982	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	12,770	6,419	0	2,186	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	481	77,156	0	26,277	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	13,114	35,576	0	12,116	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	7,668	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	9,168,547	3,401,377	332,093	1,135,167	733,994	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	715,663					11.00
13.00	01300	NURSING ADMINISTRATION	19,835	2,433,685				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,781	38,508	341,539			14.00
15.00	01500	PHARMACY	12,630	0	0	2,020,670		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,852	0	0	0	1,091,157	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,151	958,908	0	0	55,426	30.00
31.00	03100	INTENSIVE CARE UNIT	27,333	278,384	0	0	5,711	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	9,132	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,703	557,135	0	0	145,204	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	22,630	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,420	0	0	0	229,640	54.00
60.00	06000	LABORATORY	64,704	0	0	0	166,620	60.00
65.00	06500	RESPIRATORY THERAPY	24,591	0	0	0	29,147	65.00
66.00	06600	PHYSICAL THERAPY	19,295	0	0	0	18,639	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,853	0	0	0	5,651	67.00
68.00	06800	SPEECH PATHOLOGY	2,978	0	0	0	1,711	68.00
69.00	06900	ELECTROCARDIOLOGY	9,479	0	0	0	18,437	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	179	0	0	0	405	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	341,539	0	48,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	35,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,020,670	91,045	73.00
76.00	03020	ONCOLOGY	7,772	0	0	0	3,939	76.00
76.97	07697	CARDIAC REHABILITATION	3,531	0	0	0	2,973	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,139	0	0	0	54,825	90.00
91.00	09100	EMERGENCY	58,985	600,750	0	0	140,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	14,821	0	0	0	5,100	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	522,032	2,433,685	341,539	2,020,670	1,091,157	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,495	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	171,682	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	1,683	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	144	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	16,627	0	0	0	0	194.04
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)	715,663	2,433,685	341,539	2,020,670	1,091,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMITTING					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	7,907,659	0	7,907,659		30.00
31.00	03100	INTENSIVE CARE UNIT	2,547,611	0	2,547,611		31.00
41.00	04100	SUBPROVIDER - IRF	154	0	154		41.00
43.00	04300	NURSERY	563,221	0	563,221		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,689,216	0	6,689,216		50.00
53.00	05300	ANESTHESIOLOGY	215,183	0	215,183		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,413,833	0	6,413,833		54.00
60.00	06000	LABORATORY	7,200,179	0	7,200,179		60.00
65.00	06500	RESPIRATORY THERAPY	2,058,336	0	2,058,336		65.00
66.00	06600	PHYSICAL THERAPY	1,427,653	0	1,427,653		66.00
67.00	06700	OCCUPATIONAL THERAPY	479,081	0	479,081		67.00
68.00	06800	SPEECH PATHOLOGY	230,454	0	230,454		68.00
69.00	06900	ELECTROCARDIOLOGY	881,893	0	881,893		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,239	0	26,239		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,631,697	0	3,631,697		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,193,649	0	3,193,649		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,654,935	0	7,654,935		73.00
76.00	03020	ONCOLOGY	801,646	0	801,646		76.00
76.97	07697	CARDIAC REHABILITATION	421,258	0	421,258		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,921,264	0	2,921,264		90.00
91.00	09100	EMERGENCY	5,541,781	0	5,541,781		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,144,231	0	1,144,231		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,951,173	0	61,951,173		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223,064	0	223,064		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,173,972	0	20,173,972		192.00
192.01	19201	SOUTH CLINIC	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0		192.02
192.03	19203	DIABETES CENTER	125,656	0	125,656		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	107,782	0	107,782		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	166,317	0	166,317		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0		194.02
194.03	07953	JAIL	69,274	0	69,274		194.03
194.04	07954	ATHLETIC TRAINERS	16,627	0	16,627		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	-3,552,662	0	-3,552,662		201.00
202.00		TOTAL (sum lines 118 through 201)	79,281,203	0	79,281,203		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,979	1,979	1,979	4.00
4.01	00401	COMMUNICATIONS	0	0	0	0	6	4.01
4.02	00402	DATA PROCESSING	0	0	2,082,951	2,082,951	52	4.02
4.03	00403	MATERIALS MANAGEMENT	0	0	9,868	9,868	23	4.03
4.04	00404	ADMITTING	0	0	0	0	53	4.04
4.05	00405	PATIENT ACCOUNTING	0	0	17,417	17,417	69	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	43,717	43,717	149	5.00
7.00	00700	OPERATION OF PLANT	0	0	67,055	67,055	45	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	7,384	7,384	7	8.00
9.00	00900	HOUSEKEEPING	0	0	6,644	6,644	44	9.00
10.00	01000	DIETARY	0	0	30,923	30,923	16	10.00
11.00	01100	CAFETERIA	0	0	0	0	33	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	48,743	48,743	84	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	49,164	49,164	5	14.00
15.00	01500	PHARMACY	0	0	8,310	8,310	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	12,007	12,007	33	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	194,113	194,113	283	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	53,033	53,033	76	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	11	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	664,082	664,082	128	50.00
53.00	05300	ANESTHESIOLOGY	0	0	21,145	21,145	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	511,737	511,737	134	54.00
60.00	06000	LABORATORY	0	0	210,397	210,397	132	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	23,069	23,069	71	65.00
66.00	06600	PHYSICAL THERAPY	0	0	15,047	15,047	51	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,556	3,556	18	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	557	557	9	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	50,570	50,570	20	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,755	2,755	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20,904	20,904	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	3,223	3,223	21	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	15,388	15,388	9	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	24,609	24,609	48	90.00
91.00	09100	EMERGENCY	0	0	46,329	46,329	257	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	97	97	42	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	4,246,773	4,246,773	1,967	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6,649	6,649	3	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	159,606	159,606	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	0	809	809	5	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	1	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	3	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		-3,552,662	0	-3,552,662	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	-3,552,662	4,413,837	861,175	1,979	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	6					4.01
4.02	00402	DATA PROCESSING	5	2,083,008				4.02
4.03	00403	MATERIALS MANAGEMENT	0	45,102	54,993			4.03
4.04	00404	ADMITTING	0	73,097	53	73,203		4.04
4.05	00405	PATIENT ACCOUNTING	0	175,744	156	0	193,386	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	249,878	1,409	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	34,734	37	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,960	12	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	82	0	0	9.00
10.00	01000	DIETARY	0	28,513	3,174	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	38,363	921	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	694	0	0	14.00
15.00	01500	PHARMACY	0	35,252	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,171	43	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	115,089	3,293	3,568	9,046	30.00
31.00	03100	INTENSIVE CARE UNIT	0	71,542	1,013	392	993	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	203	514	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	187,149	4,177	9,797	24,838	50.00
53.00	05300	ANESTHESIOLOGY	0	0	13	1,526	3,868	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	78,281	2,541	15,587	39,296	54.00
60.00	06000	LABORATORY	0	93,315	18,888	11,324	28,711	60.00
65.00	06500	RESPIRATORY THERAPY	0	58,063	1,691	1,965	4,982	65.00
66.00	06600	PHYSICAL THERAPY	0	21,774	261	1,258	3,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,332	0	381	967	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,184	1	115	293	68.00
69.00	06900	ELECTROCARDIOLOGY	0	66,876	133	1,204	3,052	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	4	27	69	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,297	8,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,397	6,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,143	15,574	73.00
76.00	03020	ONCOLOGY	0	24,884	483	266	674	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	114	201	508	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	76,208	2,714	3,699	9,378	90.00
91.00	09100	EMERGENCY	0	82,429	2,295	9,526	24,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	21,774	184	295	749	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5	1,680,714	44,386	73,171	185,288	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,884	201	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	366,523	10,387	0	8,018	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	1,555	2	32	80	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	9,332	17	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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	2,083,008	54,993	73,203	193,386	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	295,153					5.00
7.00	00700	OPERATION OF PLANT	12,121	113,992				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,047	1,286	22,696			8.00
9.00	00900	HOUSEKEEPING	3,725	999	4,110	15,604		9.00
10.00	01000	DIETARY	2,289	2,096	529	293	67,833	10.00
11.00	01100	CAFETERIA	2,232	2,232	0	312	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,849	5,280	0	738	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	937	909	0	127	0	14.00
15.00	01500	PHARMACY	7,000	1,095	0	153	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,518	2,076	0	290	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,416	14,757	6,024	2,061	62,102	30.00
31.00	03100	INTENSIVE CARE UNIT	7,068	4,220	1,504	589	5,731	31.00
41.00	04100	SUBPROVIDER - IRF	1	0	0	0	0	41.00
43.00	04300	NURSERY	1,927	334	0	47	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,450	24,492	3,818	3,418	0	50.00
53.00	05300	ANESTHESIOLOGY	656	211	0	29	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,488	8,847	2,016	1,236	0	54.00
60.00	06000	LABORATORY	24,219	4,307	0	602	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,115	200	0	28	0	65.00
66.00	06600	PHYSICAL THERAPY	4,442	3,392	508	474	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,564	714	0	100	0	67.00
68.00	06800	SPEECH PATHOLOGY	798	44	0	6	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,949	578	235	81	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	78	97	0	14	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,550	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,254	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,753	0	0	0	0	73.00
76.00	03020	ONCOLOGY	2,281	3,745	0	523	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,286	1,344	0	188	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,239	6,163	137	861	0	90.00
91.00	09100	EMERGENCY	15,962	5,316	3,383	743	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,907	698	0	98	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	224,121	95,432	22,264	13,011	67,833	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	683	694	0	97	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69,254	13,873	432	1,938	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	411	215	0	30	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	15	2,586	0	361	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	422	1,192	0	167	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	247	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	295,153	113,992	22,696	15,604	67,833	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	4,809					11.00
13.00	01300	NURSING ADMINISTRATION	133	102,111				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25	1,616	53,477			14.00
15.00	01500	PHARMACY	85	0	0	51,933		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	140	0	0	0	93,278	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	633	40,233	0	0	4,734	30.00
31.00	03100	INTENSIVE CARE UNIT	184	11,680	0	0	488	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	780	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	368	23,376	0	0	12,403	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345	0	0	0	19,689	54.00
60.00	06000	LABORATORY	435	0	0	0	14,232	60.00
65.00	06500	RESPIRATORY THERAPY	165	0	0	0	2,490	65.00
66.00	06600	PHYSICAL THERAPY	130	0	0	0	1,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	39	0	0	0	483	67.00
68.00	06800	SPEECH PATHOLOGY	20	0	0	0	146	68.00
69.00	06900	ELECTROCARDIOLOGY	64	0	0	0	1,575	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1	0	0	0	35	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53,477	0	4,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	51,933	7,777	73.00
76.00	03020	ONCOLOGY	52	0	0	0	336	76.00
76.97	07697	CARDIAC REHABILITATION	24	0	0	0	254	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	169	0	0	0	4,683	90.00
91.00	09100	EMERGENCY	396	25,206	0	0	12,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	100	0	0	0	436	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,508	102,111	53,477	51,933	93,278	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,154	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	11	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	1	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	112	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,809	102,111	53,477	51,933	93,278	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMITTING					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	475,352	0	475,352		30.00
31.00	03100	INTENSIVE CARE UNIT	158,513	0	158,513		31.00
41.00	04100	SUBPROVIDER - IRF	1	0	1		41.00
43.00	04300	NURSERY	3,816	0	3,816		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	975,496	0	975,496		50.00
53.00	05300	ANESTHESIOLOGY	29,381	0	29,381		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	700,197	0	700,197		54.00
60.00	06000	LABORATORY	406,562	0	406,562		60.00
65.00	06500	RESPIRATORY THERAPY	99,839	0	99,839		65.00
66.00	06600	PHYSICAL THERAPY	52,117	0	52,117		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,154	0	17,154		67.00
68.00	06800	SPEECH PATHOLOGY	7,173	0	7,173		68.00
69.00	06900	ELECTROCARDIOLOGY	127,337	0	127,337		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,080	0	3,080		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,761	0	101,761		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,763	0	22,763		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,180	0	101,180		73.00
76.00	03020	ONCOLOGY	36,488	0	36,488		76.00
76.97	07697	CARDIAC REHABILITATION	19,316	0	19,316		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	137,908	0	137,908		90.00
91.00	09100	EMERGENCY	227,997	0	227,997		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	28,380	0	28,380		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,731,811	0	3,731,811		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,234	0	33,234		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	631,186	0	631,186		192.00
192.01	19201	SOUTH CLINIC	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0		192.02
192.03	19203	DIABETES CENTER	3,150	0	3,150		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	2,962	0	2,962		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	11,132	0	11,132		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0		194.02
194.03	07953	JAIL	250	0	250		194.03
194.04	07954	ATHLETIC TRAINERS	112	0	112		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	-3,552,662	0	-3,552,662		201.00
202.00		TOTAL (sum lines 118 through 201)	861,175	0	861,175		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (TOTAL FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	273,798					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,558,512				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	1,147	29,205,219			4.00
4.01	00401	COMMUNICATIONS	393	0	87,923	1,339		4.01
4.02	00402	DATA PROCESSING	6,260	1,207,398	770,890	135	4,018	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	5,720	336,396	29	87	4.03
4.04	00404	ADMITTING	2,239	0	773,909	34	141	4.04
4.05	00405	PATIENT ACCOUNTING	6,650	10,096	1,011,906	88	339	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,526	25,341	2,186,734	77	482	5.00
7.00	00700	OPERATION OF PLANT	28,905	38,869	660,564	49	67	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	4,280	100,817	5	25	8.00
9.00	00900	HOUSEKEEPING	1,867	3,851	641,899	14	0	9.00
10.00	01000	DIETARY	3,917	17,925	240,671	26	55	10.00
11.00	01100	CAFETERIA	4,171	0	489,681	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	28,254	1,239,863	46	74	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	28,498	76,893	0	0	14.00
15.00	01500	PHARMACY	2,046	4,817	564,052	23	68	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	6,960	490,739	37	145	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	112,519	4,245,066	105	222	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	30,741	1,119,267	28	138	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	625	0	161,883	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	384,940	1,886,597	88	361	50.00
53.00	05300	ANESTHESIOLOGY	394	12,257	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	296,632	1,965,956	52	151	54.00
60.00	06000	LABORATORY	8,049	121,958	1,941,363	68	180	60.00
65.00	06500	RESPIRATORY THERAPY	374	13,372	1,039,211	18	112	65.00
66.00	06600	PHYSICAL THERAPY	6,338	8,722	743,133	25	42	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	2,061	266,810	6	18	67.00
68.00	06800	SPEECH PATHOLOGY	83	323	138,624	6	10	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	29,313	294,100	43	129	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	1,597	6,682	2	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,117	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	1,868	304,831	37	48	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	8,920	135,499	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	14,265	699,565	21	147	90.00
91.00	09100	EMERGENCY	9,934	26,855	3,774,408	59	159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	56	614,193	23	42	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	239,114	2,461,672	29,010,125	1,144	3,242	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	3,854	50,611	15	48	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,925	92,517	0	164	707	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	469	73,794	3	3	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,832	0	1,836	5	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,228	0	20,853	8	18	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	48,000	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	-3,552,662	4,413,837	8,278,259	367,169	5,346,611	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1.725158	0.283451	274.211352	1,330.664759	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
			NEW BLDG & FIXT (TOTAL FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	4.01	4.02	
204.00		Cost to be allocated (per Wkst. B, Part II)			1,979	6	2,083,008	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000068	0.004481	518.419114	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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			4.03	4.04	4.05	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT	4,131,551					4.03
4.04	00404	ADMITTING	3,981	246,128,805				4.04
4.05	00405	PATIENT ACCOUNTING	11,748	0	256,777,047			4.05
5.00	00500	ADMINISTRATIVE & GENERAL	105,831	0	0	-9,168,547	73,665,318	5.00
7.00	00700	OPERATION OF PLANT	2,798	0	0	0	3,024,893	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	906	0	0	0	261,197	8.00
9.00	00900	HOUSEKEEPING	6,184	0	0	0	929,532	9.00
10.00	01000	DIETARY	238,434	0	0	0	571,299	10.00
11.00	01100	CAFETERIA	0	0	0	0	557,048	11.00
13.00	01300	NURSING ADMINISTRATION	69,210	0	0	0	1,958,837	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,155	0	0	0	233,785	14.00
15.00	01500	PHARMACY	0	0	0	0	1,746,830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,224	0	0	0	877,995	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	247,385	12,013,550	12,013,550	0	4,845,625	30.00
31.00	03100	INTENSIVE CARE UNIT	76,133	1,318,195	1,318,195	0	1,763,836	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	137	41.00
43.00	04300	NURSERY	0	682,972	682,972	0	480,861	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	313,814	32,986,001	32,986,001	0	4,354,755	50.00
53.00	05300	ANESTHESIOLOGY	1,008	5,136,959	5,136,959	0	163,740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	190,905	52,140,801	52,140,801	0	5,113,015	54.00
60.00	06000	LABORATORY	1,418,771	38,128,318	38,128,318	0	6,044,276	60.00
65.00	06500	RESPIRATORY THERAPY	127,035	6,616,358	6,616,358	0	1,775,598	65.00
66.00	06600	PHYSICAL THERAPY	19,632	4,234,136	4,234,136	0	1,108,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,283,635	1,283,635	0	390,409	67.00
68.00	06800	SPEECH PATHOLOGY	62	388,790	388,790	0	199,197	68.00
69.00	06900	ELECTROCARDIOLOGY	9,991	4,052,981	4,052,981	0	735,839	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	333	92,113	92,113	0	19,351	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,100,756	11,100,756	0	2,882,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,070,737	8,070,737	0	2,808,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,682,600	20,682,600	0	4,929,664	73.00
76.00	03020	ONCOLOGY	36,253	894,781	894,781	0	569,263	76.00
76.97	07697	CARDIAC REHABILITATION	8,587	675,276	675,276	0	321,046	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	203,927	12,454,479	12,454,479	0	2,305,807	90.00
91.00	09100	EMERGENCY	172,419	32,073,844	32,073,844	0	3,983,562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	13,837	994,817	994,817	0	975,022	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,334,563	246,022,099	246,022,099	-9,168,547	55,932,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,120	0	0	0	170,576	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	780,418	0	10,648,242	0	17,289,167	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	177	106,706	106,706	0	102,598	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	3,868	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	1,273	0	0	0	105,367	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	61,606	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	599,010	1,197,118	2,515,411		9,168,547	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.144984	0.004864	0.009796		0.124462	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,993	73,203	193,386		295,153	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			4.03	4.04	4.05	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013310	0.000297	0.000753		0.004007	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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	213,015					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	370,862				8.00
9.00	00900	HOUSEKEEPING	1,867	67,152	208,744			9.00
10.00	01000	DIETARY	3,917	8,647	3,917	17,862		10.00
11.00	01100	CAFETERIA	4,171	0	4,171	0	832,087	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	9,867	0	23,062	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	1,699	0	4,396	14.00
15.00	01500	PHARMACY	2,046	0	2,046	0	14,685	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	0	3,879	0	24,244	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	98,449	27,577	16,353	109,468	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	24,568	7,886	1,509	31,780	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	625	0	625	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	62,386	45,761	0	63,602	50.00
53.00	05300	ANESTHESIOLOGY	394	0	394	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	32,945	16,532	0	59,785	54.00
60.00	06000	LABORATORY	8,049	0	8,049	0	75,230	60.00
65.00	06500	RESPIRATORY THERAPY	374	0	374	0	28,592	65.00
66.00	06600	PHYSICAL THERAPY	6,338	8,308	6,338	0	22,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	1,335	0	6,805	67.00
68.00	06800	SPEECH PATHOLOGY	83	0	83	0	3,463	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	3,837	1,080	0	11,021	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	0	182	0	208	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	0	6,999	0	9,036	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	2,511	0	4,105	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	2,231	11,516	0	29,229	90.00
91.00	09100	EMERGENCY	9,934	55,287	9,934	0	68,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	0	1,305	0	17,232	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	178,331	363,810	174,060	17,862	606,958	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	0	1,297	0	4,064	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,925	7,052	25,925	0	199,608	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	0	402	0	1,957	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,832	0	4,832	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,228	0	2,228	0	168	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	19,332	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,401,377	332,093	1,135,167	733,994	715,663	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.967782	0.895462	5.438082	41.092487	0.860082	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	113,992	22,696	15,604	67,833	4,809	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	
			7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.535136	0.061198	0.074752	3.797615	0.005779	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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	277,827					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,396	100				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	247,850,961		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,468	0	0	12,591,184		30.00
31.00	03100	INTENSIVE CARE UNIT	31,780	0	0	1,297,334		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	2,074,424		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,602	0	0	32,986,001		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,140,820		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	52,140,801		54.00
60.00	06000	LABORATORY	0	0	0	37,851,089		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,621,278		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,234,136		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,283,635		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	388,790		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,188,412		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	92,113		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	11,100,756		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,070,737		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	20,682,600		73.00
76.00	03020	ONCOLOGY	0	0	0	894,781		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	675,276		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	12,454,479		90.00
91.00	09100	EMERGENCY	68,581	0	0	31,923,818		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	1,158,497		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	277,827	100	100	247,850,961		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	0	0	0		194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,433,685	341,539	2,020,670	1,091,157		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.759714	3,415.390000	20,206.700000	0.004402		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	102,111	53,477	51,933	93,278		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.367534	534.770000	519.330000	0.000376		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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,907,659		7,907,659	0	7,907,659	30.00
31.00	03100	INTENSIVE CARE UNIT	2,547,611		2,547,611	0	2,547,611	31.00
41.00	04100	SUBPROVIDER - IRF	154		154	0	154	41.00
43.00	04300	NURSERY	563,221		563,221	0	563,221	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,689,216		6,689,216	0	6,689,216	50.00
53.00	05300	ANESTHESIOLOGY	215,183		215,183	0	215,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,413,833		6,413,833	0	6,413,833	54.00
60.00	06000	LABORATORY	7,200,179		7,200,179	0	7,200,179	60.00
65.00	06500	RESPIRATORY THERAPY	2,058,336	0	2,058,336	0	2,058,336	65.00
66.00	06600	PHYSICAL THERAPY	1,427,653	0	1,427,653	0	1,427,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	479,081	0	479,081	0	479,081	67.00
68.00	06800	SPEECH PATHOLOGY	230,454	0	230,454	0	230,454	68.00
69.00	06900	ELECTROCARDIOLOGY	881,893		881,893	28,953	910,846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,239		26,239	0	26,239	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,631,697		3,631,697	0	3,631,697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,193,649		3,193,649	0	3,193,649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,654,935		7,654,935	0	7,654,935	73.00
76.00	03020	ONCOLOGY	801,646		801,646	105,414	907,060	76.00
76.97	07697	CARDIAC REHABILITATION	421,258		421,258	0	421,258	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,921,264		2,921,264	0	2,921,264	90.00
91.00	09100	EMERGENCY	5,541,781		5,541,781	0	5,541,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,132,225		1,132,225		1,132,225	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,144,231		1,144,231		1,144,231	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	63,083,398	0	63,083,398	134,367	63,217,765	200.00
201.00		Less Observation Beds	1,132,225		1,132,225		1,132,225	201.00
202.00		Total (see instructions)	61,951,173	0	61,951,173	134,367	62,085,540	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,710,704		10,710,704			30.00
31.00	03100	INTENSIVE CARE UNIT	1,297,334		1,297,334			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	2,074,424		2,074,424			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,276,411	26,709,590	32,986,001	0.202790	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	832,328	4,308,492	5,140,820	0.041858	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,204,270	45,936,531	52,140,801	0.123010	0.000000	54.00
60.00	06000	LABORATORY	7,838,654	30,012,435	37,851,089	0.190224	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,369,780	3,251,498	6,621,278	0.310867	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	450,018	3,784,118	4,234,136	0.337177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	421,659	861,976	1,283,635	0.373222	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	151,005	237,785	388,790	0.592747	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,046,731	3,141,681	4,188,412	0.210555	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,253	55,860	92,113	0.284857	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,421,914	7,678,842	11,100,756	0.327158	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,441,405	4,629,332	8,070,737	0.395707	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,526,687	16,155,913	20,682,600	0.370115	0.000000	73.00
76.00	03020	ONCOLOGY	3,654	891,127	894,781	0.895913	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	283	674,993	675,276	0.623831	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,904	12,447,575	12,454,479	0.234555	0.000000	90.00
91.00	09100	EMERGENCY	3,771,844	28,151,974	31,923,818	0.173594	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	240,009	1,640,471	1,880,480	0.602094	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,158,497	1,158,497			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,122,271	191,728,690	247,850,961			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	56,122,271	191,728,690	247,850,961			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.202790		50.00
53.00	05300	ANESTHESIOLOGY	0.041858		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123010		54.00
60.00	06000	LABORATORY	0.190224		60.00
65.00	06500	RESPIRATORY THERAPY	0.310867		65.00
66.00	06600	PHYSICAL THERAPY	0.337177		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373222		67.00
68.00	06800	SPEECH PATHOLOGY	0.592747		68.00
69.00	06900	ELECTROCARDIOLOGY	0.217468		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.284857		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327158		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.395707		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370115		73.00
76.00	03020	ONCOLOGY	1.013723		76.00
76.97	07697	CARDIAC REHABILITATION	0.623831		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.234555		90.00
91.00	09100	EMERGENCY	0.173594		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602094		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/27/2020 4:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,907,659		7,907,659	0	7,907,659	30.00
31.00	03100	INTENSIVE CARE UNIT	2,547,611		2,547,611	0	2,547,611	31.00
41.00	04100	SUBPROVIDER - IRF	154		154	0	154	41.00
43.00	04300	NURSERY	563,221		563,221	0	563,221	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,689,216		6,689,216	0	6,689,216	50.00
53.00	05300	ANESTHESIOLOGY	215,183		215,183	0	215,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,413,833		6,413,833	0	6,413,833	54.00
60.00	06000	LABORATORY	7,200,179		7,200,179	0	7,200,179	60.00
65.00	06500	RESPIRATORY THERAPY	2,058,336	0	2,058,336	0	2,058,336	65.00
66.00	06600	PHYSICAL THERAPY	1,427,653	0	1,427,653	0	1,427,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	479,081	0	479,081	0	479,081	67.00
68.00	06800	SPEECH PATHOLOGY	230,454	0	230,454	0	230,454	68.00
69.00	06900	ELECTROCARDIOLOGY	881,893		881,893	28,953	910,846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,239		26,239	0	26,239	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,631,697		3,631,697	0	3,631,697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,193,649		3,193,649	0	3,193,649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,654,935		7,654,935	0	7,654,935	73.00
76.00	03020	ONCOLOGY	801,646		801,646	105,414	907,060	76.00
76.97	07697	CARDIAC REHABILITATION	421,258		421,258	0	421,258	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,921,264		2,921,264	0	2,921,264	90.00
91.00	09100	EMERGENCY	5,541,781		5,541,781	0	5,541,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,132,225		1,132,225		1,132,225	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,144,231		1,144,231		1,144,231	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	63,083,398	0	63,083,398	134,367	63,217,765	200.00
201.00		Less Observation Beds	1,132,225		1,132,225		1,132,225	201.00
202.00		Total (see instructions)	61,951,173	0	61,951,173	134,367	62,085,540	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/27/2020 4:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,710,704		10,710,704			30.00
31.00	03100	INTENSIVE CARE UNIT	1,297,334		1,297,334			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	2,074,424		2,074,424			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,276,411	26,709,590	32,986,001	0.202790	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	832,328	4,308,492	5,140,820	0.041858	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,204,270	45,936,531	52,140,801	0.123010	0.000000	54.00
60.00	06000	LABORATORY	7,838,654	30,012,435	37,851,089	0.190224	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,369,780	3,251,498	6,621,278	0.310867	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	450,018	3,784,118	4,234,136	0.337177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	421,659	861,976	1,283,635	0.373222	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	151,005	237,785	388,790	0.592747	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,046,731	3,141,681	4,188,412	0.210555	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,253	55,860	92,113	0.284857	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,421,914	7,678,842	11,100,756	0.327158	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,441,405	4,629,332	8,070,737	0.395707	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,526,687	16,155,913	20,682,600	0.370115	0.000000	73.00
76.00	03020	ONCOLOGY	3,654	891,127	894,781	0.895913	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	283	674,993	675,276	0.623831	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,904	12,447,575	12,454,479	0.234555	0.000000	90.00
91.00	09100	EMERGENCY	3,771,844	28,151,974	31,923,818	0.173594	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	240,009	1,640,471	1,880,480	0.602094	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,158,497	1,158,497			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,122,271	191,728,690	247,850,961			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	56,122,271	191,728,690	247,850,961			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/27/2020 4:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	475,352	0	475,352	6,181	76.91	30.00
31.00	INTENSIVE CARE UNIT	158,513		158,513	503	315.14	31.00
41.00	SUBPROVIDER - IRF	1	0	1	0	0.00	41.00
43.00	NURSERY	3,816		3,816	736	5.18	43.00
200.00	Total (lines 30 through 199)	637,682		637,682	7,420		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,122	163,203	30.00
31.00	INTENSIVE CARE UNIT	241	75,949	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	2,363	239,152	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	975,496	32,986,001	0.029573	1,855,260	54,866	50.00
53.00	05300	ANESTHESIOLOGY	29,381	5,140,820	0.005715	243,060	1,389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	700,197	52,140,801	0.013429	2,507,590	33,674	54.00
60.00	06000	LABORATORY	406,562	37,851,089	0.010741	3,537,252	37,994	60.00
65.00	06500	RESPIRATORY THERAPY	99,839	6,621,278	0.015079	1,297,512	19,565	65.00
66.00	06600	PHYSICAL THERAPY	52,117	4,234,136	0.012309	215,578	2,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,154	1,283,635	0.013364	201,325	2,691	67.00
68.00	06800	SPEECH PATHOLOGY	7,173	388,790	0.018450	84,080	1,551	68.00
69.00	06900	ELECTROCARDIOLOGY	127,337	4,188,412	0.030402	927,252	28,190	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,080	92,113	0.033437	18,670	624	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,761	11,100,756	0.009167	1,214,848	11,137	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,763	8,070,737	0.002820	1,400,962	3,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,180	20,682,600	0.004892	1,845,773	9,030	73.00
76.00	03020	ONCOLOGY	36,488	894,781	0.040779	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	19,316	675,276	0.028605	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	137,908	12,454,479	0.011073	5,606	62	90.00
91.00	09100	EMERGENCY	227,997	31,923,818	0.007142	1,701,666	12,153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	68,061	1,880,480	0.036193	240,009	8,687	92.00
200.00		Total (lines 50 through 199)	3,133,810	232,610,002		17,296,443	228,218	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,181	0.00	2,122	30.00
31.00	03100	INTENSIVE CARE UNIT		0	503	0.00	241	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	736	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	7,420		2,363	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	32,986,001	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,140,820	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	52,140,801	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	37,851,089	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,621,278	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,234,136	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,283,635	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	388,790	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,188,412	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	92,113	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,100,756	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,070,737	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,682,600	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	894,781	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	675,276	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	12,454,479	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	31,923,818	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,880,480	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	232,610,002		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,855,260	0	6,498,035	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	243,060	0	702,120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,507,590	0	10,323,436	0	54.00
60.00	06000	LABORATORY	0.000000	3,537,252	0	2,717,098	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,297,512	0	697,372	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	215,578	0	5,256	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	201,325	0	3,112	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	84,080	0	6,057	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	927,252	0	1,184,488	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	18,670	0	18,360	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,214,848	0	1,328,332	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,400,962	0	1,124,026	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,845,773	0	5,826,776	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	103,715	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	138,677	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	5,606	0	3,008,858	0	90.00
91.00	09100	EMERGENCY	0.000000	1,701,666	0	4,721,944	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	240,009	0	475,059	0	92.00
200.00		Total (lines 50 through 199)		17,296,443	0	38,882,721	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202790	6,498,035	0	0	1,317,737	50.00
53.00	05300	ANESTHESIOLOGY	0.041858	702,120	0	0	29,389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123010	10,323,436	0	0	1,269,886	54.00
60.00	06000	LABORATORY	0.190224	2,717,098	0	0	516,857	60.00
65.00	06500	RESPIRATORY THERAPY	0.310867	697,372	0	0	216,790	65.00
66.00	06600	PHYSICAL THERAPY	0.337177	5,256	0	0	1,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373222	3,112	0	0	1,161	67.00
68.00	06800	SPEECH PATHOLOGY	0.592747	6,057	0	0	3,590	68.00
69.00	06900	ELECTROCARDIOLOGY	0.210555	1,184,488	0	0	249,400	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.284857	18,360	0	0	5,230	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327158	1,328,332	0	0	434,574	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.395707	1,124,026	0	0	444,785	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370115	5,826,776	0	0	2,156,577	73.00
76.00	03020	ONCOLOGY	0.895913	103,715	0	0	92,920	76.00
76.97	07697	CARDIAC REHABILITATION	0.623831	138,677	0	0	86,511	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.234555	3,008,858	1,518	0	705,743	90.00
91.00	09100	EMERGENCY	0.173594	4,721,944	0	0	819,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602094	475,059	792	0	286,030	92.00
200.00		Subtotal (see instructions)		38,882,721	2,310	0	8,638,653	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		38,882,721	2,310	0	8,638,653	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	356	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	477	0		92.00
200.00		Subtotal (see instructions)	833	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	833	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,181	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,181	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)	5,296	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,122	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,907,659	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,907,659	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)	7,907,659	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,279.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,714,781	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,714,781	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,547,611	503	5,064.83	241	1,220,624	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)	4,251,903	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,187,308	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)	239,152	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	228,218	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	467,370	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,719,938	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)	885	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,279.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,132,225	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	475,352	7,907,659	0.060113	1,132,225	68,061	90.00
91.00	Nursing School cost	0	7,907,659	0.000000	1,132,225	0	91.00
92.00	Allied health cost	0	7,907,659	0.000000	1,132,225	0	92.00
93.00	All other Medical Education	0	7,907,659	0.000000	1,132,225	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/27/2020 4:01 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,181	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,181	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)	5,296	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	134	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)	736	15.00
16.00	Nursery days (title V or XIX only)	42	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,907,659	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,907,659	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)	7,907,659	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,279.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	171,433	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)	171,433	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/27/2020 4:01 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	563,221	736	765.25	42	32,141	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,547,611	503	5,064.83	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	127,881	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	331,455	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)	885	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,279.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,132,225	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/27/2020 4:01 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	475,352	7,907,659	0.060113	1,132,225	68,061	90.00
91.00	Nursing School cost	0	7,907,659	0.000000	1,132,225	0	91.00
92.00	Allied health cost	0	7,907,659	0.000000	1,132,225	0	92.00
93.00	All other Medical Education	0	7,907,659	0.000000	1,132,225	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,491,819		30.00
31.00	03100	INTENSIVE CARE UNIT		564,165		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202790	1,855,260	376,228	50.00
53.00	05300	ANESTHESIOLOGY	0.041858	243,060	10,174	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123010	2,507,590	308,459	54.00
60.00	06000	LABORATORY	0.190224	3,537,252	672,870	60.00
65.00	06500	RESPIRATORY THERAPY	0.310867	1,297,512	403,354	65.00
66.00	06600	PHYSICAL THERAPY	0.337177	215,578	72,688	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373222	201,325	75,139	67.00
68.00	06800	SPEECH PATHOLOGY	0.592747	84,080	49,838	68.00
69.00	06900	ELECTROCARDIOLOGY	0.217468	927,252	201,648	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.284857	18,670	5,318	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327158	1,214,848	397,447	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.395707	1,400,962	554,370	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370115	1,845,773	683,148	73.00
76.00	03020	ONCOLOGY	1.013723	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.623831	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.234555	5,606	1,315	90.00
91.00	09100	EMERGENCY	0.173594	1,701,666	295,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602094	240,009	144,508	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		17,296,443	4,251,903	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)		17,296,443		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/27/2020 4:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		433,804		30.00
31.00	03100	INTENSIVE CARE UNIT		8,286		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202790	223,717	45,368	50.00
53.00	05300	ANESTHESIOLOGY	0.041858	30,319	1,269	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123010	50,082	6,161	54.00
60.00	06000	LABORATORY	0.190224	111,464	21,203	60.00
65.00	06500	RESPIRATORY THERAPY	0.310867	21,266	6,611	65.00
66.00	06600	PHYSICAL THERAPY	0.337177	1,857	626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373222	1,542	576	67.00
68.00	06800	SPEECH PATHOLOGY	0.592747	388	230	68.00
69.00	06900	ELECTROCARDIOLOGY	0.210555	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.284857	133	38	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327158	27,479	8,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.395707	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370115	76,249	28,221	73.00
76.00	03020	ONCOLOGY	0.895913	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.623831	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.234555	0	0	90.00
91.00	09100	EMERGENCY	0.173594	49,474	8,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602094	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		593,970	127,881	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)		593,970		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 4:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,496,573	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	109,114	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	46.44	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.71	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.07	31.00
32.00	Sum of lines 30 and 31	24.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.66	33.00
34.00	Disproportionate share adjustment (see instructions)	132,742	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 4:01 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	815,209	731,656	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	609,731	183,913	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	793,644		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,532,073		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,532,073	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	445,200	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,977,273	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,977,273	61.00
62.00	Deductibles billed to program beneficiaries	726,724	62.00
63.00	Coinsurance billed to program beneficiaries	682	63.00
64.00	Allowable bad debts (see instructions)	26,858	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	17,458	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,858	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,267,325	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	49,436	70.93
70.94	HRR adjustment amount (see instructions)	-7,271	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 4:01 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,309,490	71.00
71.01	Sequestration adjustment (see instructions)		126,190	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		6,130,668	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		52,632	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		84,437	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,496,573	0		5,496,573	5,496,573	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	109,114	0		109,114	109,114	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0966	0.0966	0.0966	0.0966		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	132,742	0	0	132,742	132,742	11.00
11.01	Uncompensated care payments	36.00	793,644	0	609,731	183,913	793,644	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,532,073	0	609,731	5,922,342	6,532,073	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,532,073	0	609,731	5,922,342	6,532,073	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	445,200	0	-114,794	559,994	445,200	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	494,937	6,482,336	6,977,273	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	445,200	0	-112,215	557,415	445,200	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	-2,579	2,579	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	445,200	0	-114,794	559,994	445,200	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,496,573		5,496,573	5,496,573	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	109,114		109,114	109,114	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0966	0.0966	0.0966		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	132,742	0	132,742	132,742	11.00
11.01	Uncompensated care payments	36.00	793,644	609,731	183,913	793,644	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,532,073	609,731	5,922,342	6,532,073	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,532,073	609,731	5,922,342	6,532,073	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	445,200	-114,794	559,994	445,200	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			494,937	6,482,336	6,977,273	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	445,200	-112,215	557,415	445,200	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	-2,579	2,579	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	445,200	-114,794	559,994	445,200	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	49,436	0	49,436	49,436	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-7,271	0	-7,271	-7,271	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part B Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	833	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,638,653	2.00
3.00	OPPS payments	6,480,091	3.00
4.00	Outlier payment (see instructions)	17,649	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)	833	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,310	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)	2,310	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)	2,310	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,477	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)	833	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)	6,497,740	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,277,017	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)	5,221,556	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)	5,221,556	30.00
31.00	Primary payer payments	631	31.00
32.00	Subtotal (line 30 minus line 31)	5,220,925	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)	94,756	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	61,591	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	94,756	36.00
37.00	Subtotal (see instructions)	5,282,516	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-17	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)	5,282,533	40.00
40.01	Sequestration adjustment (see instructions)	105,651	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	5,188,552	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)	-11,670	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,070,368		5,115,710	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2019	23,500	12/31/2019	72,842	3.01
3.02		08/13/2019	36,800		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)		60,300		72,842	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,130,668		5,188,552	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		52,632		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		11,670	6.02
7.00	Total Medicare program liability (see instructions)		6,183,300		5,176,882	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: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/27/2020 4:01 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 8/27/2020 4:01 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	331,455		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	331,455	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	331,455	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	442,090		8.00
9.00	Ancillary service charges	593,970	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,036,060	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,036,060	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	704,605	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	331,455	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	331,455	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	331,455	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	331,455	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	331,455	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	331,455	0	40.00
41.00	Interim payments	627,727	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-296,272	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 8/27/2020 4:01 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,613,673	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	8,739,894	0	0	0	4.00
5.00	Other receivable	3,117,628	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,107,329	0	0	0	7.00
8.00	Prepaid expenses	61,788,691	0	0	0	8.00
9.00	Other current assets	161,694	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)	77,528,909	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,743,426	0	0	0	12.00
13.00	Land improvements	2,880,819	0	0	0	13.00
14.00	Accumulated depreciation	-1,422,184	0	0	0	14.00
15.00	Buildings	68,523,048	0	0	0	15.00
16.00	Accumulated depreciation	-29,401,644	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	13,108,408	0	0	0	19.00
20.00	Accumulated depreciation	-11,417,415	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	92,382,840	0	0	0	23.00
24.00	Accumulated depreciation	-38,686,315	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)	100,710,983	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	71,375	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	32,729,539	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,800,914	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	211,040,806	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,832,525	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,464,371	0	0	0	38.00
39.00	Payroll taxes payable	889,588	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-333,247	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,853,237	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,948,204	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,948,204	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	27,801,441	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	183,239,365				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)	183,239,365	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	211,040,806	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 8/27/2020 4:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		171,923,632		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,315,733				2.00
3.00	Total (sum of line 1 and line 2)		183,239,365		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		183,239,365		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)		183,239,365		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/27/2020 4:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,738,084		12,738,084	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,738,084		12,738,084	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,297,335		1,297,335	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)	1,297,335		1,297,335	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,035,419		14,035,419	17.00
18.00	Ancillary services	38,021,053	148,330,173	186,351,226	18.00
19.00	Outpatient services	4,049,525	42,256,294	46,305,819	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,158,497	1,158,497	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	NRCC	0	109,750	109,750	27.00
27.01	PRO FEES	0	14,096,403	14,096,403	27.01
27.02	OTHER	0	0	0	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	56,105,997	205,951,117	262,057,114	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		89,371,516		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)		89,371,516		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 8/27/2020 4:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	262,057,114	1.00
2.00	Less contractual allowances and discounts on patients' accounts	177,754,135	2.00
3.00	Net patient revenues (line 1 minus line 2)	84,302,979	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	89,371,516	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,068,537	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	526,444	24.00
24.01	NON-OPERATING INCOME	1,138,517	24.01
24.02	UPL INCOME	14,716,904	24.02
24.03	REONCILING ITEM	2,405	24.03
25.00	Total other income (sum of lines 6-24)	16,384,270	25.00
26.00	Total (line 5 plus line 25)	11,315,733	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,315,733	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	176,862	0	35,902	0	66,030	278,794	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	210,974	0	0	0	0	210,974	6.00
7.00	Physical Therapy	118,567	0	0	0	0	118,567	7.00
8.00	Occupational Therapy	83,242	0	0	0	0	83,242	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	99	0	0	0	0	99	10.00
11.00	Home Health Aide	30,864	0	0	0	0	30,864	11.00
12.00	Supplies (see instructions)	0	0	0	0	10,996	10,996	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	620,608	0	35,902	0	77,026	733,536	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	278,794	0	278,794			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	-11,490	199,484	0	199,484			6.00
7.00	Physical Therapy	0	118,567	0	118,567			7.00
8.00	Occupational Therapy	0	83,242	0	83,242			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	99	0	99			10.00
11.00	Home Health Aide	0	30,864	0	30,864			11.00
12.00	Supplies (see instructions)	0	10,996	0	10,996			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-11,490	722,046	0	722,046			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-1 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	278,794	0	0	0	0	278,794	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	199,484	0	0	0	0	199,484	6.00
7.00	Physical Therapy	118,567	0	0	0	0	118,567	7.00
8.00	Occupational Therapy	83,242	0	0	0	0	83,242	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	99	0	0	0	0	99	10.00
11.00	Home Health Aide	30,864	0	0	0	0	30,864	11.00
12.00	Supplies (see instructions)	10,996	0	0	0	0	10,996	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	722,046	0	0	0	0	722,046	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	278,794		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	125,470	324,954	6.00
7.00	Physical Therapy	74,576	193,143	7.00
8.00	Occupational Therapy	52,357	135,599	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	62	161	10.00
11.00	Home Health Aide	19,413	50,277	11.00
12.00	Supplies (see instructions)	6,916	17,912	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		722,046	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-1 Part II Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-278,794	443,252	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	199,484	6.00
7.00	Physical Therapy	0	0	0	0	0	118,567	7.00
8.00	Occupational Therapy	0	0	0	0	0	83,242	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	99	10.00
11.00	Home Health Aide	0	0	0	0	0	30,864	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	10,996	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-278,794	443,252	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		278,794	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.628974	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	
		0	1.00	2.00	4.00	4.01	4.02	
1.00	Administrative and General	0	0	97	174,094	6,307	55,888	1.00
2.00	Skilled Nursing Care	324,954	0	0	0	0	0	2.00
3.00	Physical Therapy	193,143	0	0	0	0	0	3.00
4.00	Occupational Therapy	135,599	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	161	0	0	0	0	0	6.00
7.00	Home Health Aide	50,277	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	17,912	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	722,046	0	97	174,094	6,307	55,888	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		4.03	4.04	4.05	4A.05	5.00	7.00	
1.00	Administrative and General	2,006	4,839	9,745	252,976	31,486	20,838	1.00
2.00	Skilled Nursing Care	0	0	0	324,954	40,444	0	2.00
3.00	Physical Therapy	0	0	0	193,143	24,039	0	3.00
4.00	Occupational Therapy	0	0	0	135,599	16,877	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	161	20	0	6.00
7.00	Home Health Aide	0	0	0	50,277	6,258	0	7.00
8.00	Supplies (see instructions)	0	0	0	17,912	2,229	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,006	4,839	9,745	975,022	121,353	20,838	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	7,097	0	14,821	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	7,097	0	14,821	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	5,100	332,318	0	332,318		1.00
2.00	Skilled Nursing Care	0	0	365,398	0	365,398	149,558	2.00
3.00	Physical Therapy	0	0	217,182	0	217,182	88,893	3.00
4.00	Occupational Therapy	0	0	152,476	0	152,476	62,409	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	181	0	181	74	6.00
7.00	Home Health Aide	0	0	56,535	0	56,535	23,140	7.00
8.00	Supplies (see instructions)	0	0	20,141	0	20,141	8,244	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	5,100	1,144,231	0	1,144,231	332,318	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.409302	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

	Cost Center Description	Total HHA Costs				
		28.00				
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	514,956				2.00
3.00	Physical Therapy	306,075				3.00
4.00	Occupational Therapy	214,885				4.00
5.00	Speech Pathology	0				5.00
6.00	Medical Social Services	255				6.00
7.00	Home Health Aide	79,675				7.00
8.00	Supplies (see instructions)	28,385				8.00
9.00	Drugs	0				9.00
10.00	DME	0				10.00
11.00	Home Dialysis Aide Services	0				11.00
12.00	Respiratory Therapy	0				12.00
13.00	Private Duty Nursing	0				13.00
14.00	Clinic	0				14.00
15.00	Health Promotion Activities	0				15.00
16.00	Day Care Program	0				16.00
17.00	Home Delivered Meals Program	0				17.00
18.00	Homemaker Service	0				18.00
19.00	All Others (specify)	0				19.00
19.50	Telemedicine	0				19.50
20.00	Total (sum of lines 1-19) (2)	1,144,231				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part II | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (TOTAL FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	
		1.00	2.00	4.00	4.01	4.02	4.03	
1.00	Administrative and General	1,305	56	614,193	23	42	13,837	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	56	614,193	23	42	13,837	20.00
21.00	Total cost to be allocated	0	97	174,094	6,307	55,888	2,006	21.00
22.00	Unit cost multiplier	0.000000	1.732143	0.283452	274.217391	1,330.666667	0.144974	22.00

	Cost Center Description	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		4.04	4.05	5A	5.00	7.00	8.00	
1.00	Administrative and General	994,817	994,817	0	252,976	1,305	0	1.00
2.00	Skilled Nursing Care	0	0	0	324,954	0	0	2.00
3.00	Physical Therapy	0	0	0	193,143	0	0	3.00
4.00	Occupational Therapy	0	0	0	135,599	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	161	0	0	6.00
7.00	Home Health Aide	0	0	0	50,277	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	17,912	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	994,817	994,817		975,022	1,305	0	20.00
21.00	Total cost to be allocated	4,839	9,745		121,353	20,838	0	21.00
22.00	Unit cost multiplier	0.004864	0.009796		0.124462	15.967816	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part II | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

	Cost Center Description	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	1,305	0	17,232	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	0	17,232	0	0	0	20.00
21.00	Total cost to be allocated	7,097	0	14,821	0	0	0	21.00
22.00	Unit cost multiplier	5.438314	0.000000	0.860086	0.000000	0.000000	0.000000	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
1.00	Administrative and General	1,158,497	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19)	1,158,497	20.00
21.00	Total cost to be allocated	5,100	21.00
22.00	Unit cost multiplier	0.004402	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	514,956		514,956	2,533	203.30	1.00
2.00	Physical Therapy	3.00	306,075	0	306,075	1,494	204.87	2.00
3.00	Occupational Therapy	4.00	214,885	0	214,885	973	220.85	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	255		255	1	255.00	5.00
6.00	Home Health Aide	7.00	79,675		79,675	2	39,837.50	6.00
7.00	Total (sum of lines 1-6)		1,115,846	0	1,115,846	5,003		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	0			8.00
8.01	Skilled Nursing Care		26900	0	1,366			8.01
9.00	Physical Therapy		18020	0	0			9.00
9.01	Physical Therapy		26900	0	829			9.01
10.00	Occupational Therapy		18020	0	598			10.00
10.01	Occupational Therapy		26900	0	0			10.01
11.00	Speech Pathology		18020	0	0			11.00
11.01	Speech Pathology		26900	0	0			11.01
12.00	Medical Social Services		18020	0	0			12.00
12.01	Medical Social Services		26900	0	0			12.01
13.00	Home Health Aide		18020	0	0			13.00
13.01	Home Health Aide		26900	0	0			13.01
14.00	Total (sum of lines 8-13)			0	2,793			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	28,385	0	28,385	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,366		0	277,708		1.00
2.00	Physical Therapy	0	829		0	169,837		2.00
3.00	Occupational Therapy	0	598		0	132,068		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	2,793		0	579,613		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part I | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	10,816	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	277,708						1.00
2.00	Physical Therapy	169,837						2.00
3.00	Occupational Therapy	132,068						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	579,613						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part II Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.337177	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.373222	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.592747	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.327158	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.370115	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-4 Part I-II | Date/Time Prepared: 8/27/2020 4:01 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	543,319	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	3,722	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	8,085	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	555,126	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	555,126	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	555,126	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	555,126	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	555,126	31.00
31.01	Sequestration adjustment (see instructions)	0	11,103	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	544,022	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-5 | Date/Time Prepared: 8/27/2020 4:01 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		544,022	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		544,022	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		544,023	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/27/2020 4:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	445,200	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	16.18	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	445,200	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00