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: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/8/2020 3:16 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 6/8/2020 Time: 3:16 pm
2. [ ] Manually submitted 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 REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
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	-439,096	-14,985	0	0	1.00
2.00	Subprovider - IPF	0	64,418	528		0	2.00
3.00	Subprovider - IRF	0	-26,504	6		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-401,182	-14,451	0	0	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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 3:16 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 CHESTER BOULEVARD	PO Box:			1.00
2.00	City: RICHMOND	State: IN	Zip Code: 47374	County: WAYNE	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	REID HOSPITAL & HEALTH CARE SERVICES	150048	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	SUBPROVIDER	15S048	99915	4	01/01/2001	N	P	O	4.00
5.00	Subprovider - IRF	REHAB UNIT	15T048	99915	5	01/01/2003	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE	151524	99915		11/03/1993				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 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.	1,835	221	404	134	6,392	134	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 3:16 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	32	0	0	267		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	01/01/2019	12/31/2019	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/8/2020 3:16 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/8/2020 3:16 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.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 3:16 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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.	Y	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.06	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/8/2020 3:16 pm

	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: REID HOME OFFICE	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1100 REID PARKWAY	PO Box:		142.00
143.00	City: RICHMOND	State: IN	Zip Code: 47374	143.00

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

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

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

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

		1.00	
	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

		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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/8/2020 3:16 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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/28/2020	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2020	Y	04/01/2020 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/8/2020 3:16 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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				Y	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.				Y	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.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					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.	KERRY		BEJARANO		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173834000		KBEJARANO@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/8/2020 3:16 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.	SENIOR MANAGING CONSULTANT		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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 6/8/2020 3:16 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	133	48,545	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)		133	48,545	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	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)		163	59,495	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	38	13,870		0	16.00
17.00	SUBPROVIDER - IRF	41.00	20	7,300		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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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)		221				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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/8/2020 3:16 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)	18,784	1,545	37,783			1.00
2.00	HMO and other (see instructions)	3,919	7,151				2.00
3.00	HMO IPF Subprovider	894	1,296				3.00
4.00	HMO IRF Subprovider	288	299				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)	18,784	1,545	37,783			7.00
8.00	INTENSIVE CARE UNIT	2,708	213	5,176			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		77	1,889			13.00
14.00	Total (see instructions)	21,492	1,835	44,848	15.47	1,364.57	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	5,589	102	8,936	0.00	57.63	16.00
17.00	SUBPROVIDER - IRF	2,744	0	4,174	0.00	23.40	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	917	50	1,166	0.00	22.21	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				15.47	1,467.81	27.00
28.00	Observation Bed Days		315	4,722			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			574			30.00
31.00	Employee discount days - IRF			86			31.00
32.00	Labor & delivery days (see instructions)	0	134	196			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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/8/2020 3:16 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	5,841	459	11,209	1.00
2.00	HMO and other (see instructions)			913	1,787		2.00
3.00	HMO IPF Subprovider				132		3.00
4.00	HMO IRF Subprovider				20		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	5,841	459	11,209	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	374	0	647	16.00
17.00	SUBPROVIDER - IRF	0.00	0	207	0	281	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 6/8/2020 3:16 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	86,913,294	0	86,913,294	3,089,162.63	28.13	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		0	0	0	0.00	0.00	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	1,703,560	1,703,560	36,118.27	47.17	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,274,997	508,446	6,783,443	245,333.53	27.65	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		7,327,154	0	7,327,154	133,840.66	54.75	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		577,217	0	577,217	3,848.12	150.00	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		15,474,561	0	15,474,561	581,753.79	26.60	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		22,874,483	0	22,874,483			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,033,895	0	2,033,895			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		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		313,675	0	313,675			25.00
25.50	Home office wage-related (core)		3,464,709	0	3,464,709			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
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	273,126	0	273,126	11,067.32	24.68	26.00
27.00	Administrative & General	5.00	6,531,737	114,186	6,645,923	288,491.25	23.04	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 6/8/2020 3:16 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	
28.00	Administrative & General under contract (see inst.)		3,819,225	0	3,819,225	57,596.67	66.31	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	327,775	0	327,775	14,316.91	22.89	30.00
31.00	Laundry & Linen Service	8.00	516,302	-168,229	348,073	22,683.61	15.34	31.00
32.00	Housekeeping	9.00	2,047,038	0	2,047,038	138,019.84	14.83	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,074,633	-2,453,746	620,887	37,752.57	16.45	34.00
35.00	Dietary under contract (see instructions)		17,640	0	17,640	264.00	66.82	35.00
36.00	Cafeteria	11.00	0	2,453,746	2,453,746	149,143.01	16.45	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	220,719	220,719	2,080.00	106.11	38.00
39.00	Central Services and Supply	14.00	643,107	0	643,107	38,766.10	16.59	39.00
40.00	Pharmacy	15.00	4,161,967	0	4,161,967	122,118.33	34.08	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	3,795,580	0	3,795,580	116,721.11	32.52	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 6/8/2020 3:16 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)		90,750,159	-1,703,560	89,046,599	3,110,905.03	28.62	1.00
2.00	Excluded area salaries (see instructions)		6,274,997	508,446	6,783,443	245,333.53	27.65	2.00
3.00	Subtotal salaries (line 1 minus line 2)		84,475,162	-2,212,006	82,263,156	2,865,571.50	28.71	3.00
4.00	Subtotal other wages & related costs (see inst.)		23,378,932	0	23,378,932	719,442.57	32.50	4.00
5.00	Subtotal wage-related costs (see inst.)		26,339,192	0	26,339,192	0.00	32.02	5.00
6.00	Total (sum of lines 3 thru 5)		134,193,286	-2,212,006	131,981,280	3,585,014.07	36.81	6.00
7.00	Total overhead cost (see instructions)		25,208,130	166,676	25,374,806	999,020.72	25.40	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part IV Date/Time Prepared: 6/8/2020 3:16 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	3,047,135	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)	13,592,053	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	86,540	9.00
10.00	Dental, Hearing and Vision Plan	521,489	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	109,752	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)	357,707	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	656,992	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	6,480,767	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	84,275	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	285,343	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	25,222,053	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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part V Date/Time Prepared: 6/8/2020 3:16 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	7,327,154	25,222,053	1.00
2.00	Hospital	7,327,154	23,188,158	2.00
3.00	Subprovider - IPF	0	986,439	3.00
4.00	Subprovider - IRF	0	451,728	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			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	407,186	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	188,542	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	14,098	775	2,598	17,471	11.00
12.00	Hospice Inpatient Respite Care	122	1	22	145	12.00
13.00	Hospice General Inpatient Care	795	49	177	1,021	13.00
14.00	Total Hospice Days	15,015	825	2,797	18,637	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 6/8/2020 3:16 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)	0.283682	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	56,076,851	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	169,597,241	6.00
7.00	Medicaid cost (line 1 times line 6)	48,111,685	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	13,608,120	3,329,557	16,937,677	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,860,379	3,329,557	7,189,936	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)	3,860,379	3,329,557	7,189,936	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)	18,994,796	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,336,124	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,055,575	27.01
28.00	Non-Medicare bad debt expense (see instructions)	16,939,221	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,524,803	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	12,714,739	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,714,739	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/8/2020 3:16 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		0	0	20,044,837	20,044,837	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE		0	0	6,215,457	6,215,457	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	273,126	32,954	306,080	-3,113	302,967	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	236,700	3,394,463	3,631,163	0	3,631,163	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	40,848	17,593	58,441	0	58,441	5.03
5.04	00570	ADMITTING	3,084,816	1,403,315	4,488,131	-15,176	4,472,955	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	259,499	259,499	-165,919	93,580	5.05
5.06	00590	OTHER A&G	3,169,373	17,381,720	20,551,093	-131,235	20,419,858	5.06
7.00	00700	OPERATION OF PLANT	327,775	-21,525	306,250	0	306,250	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	516,302	503,670	1,019,972	-308,304	711,668	8.00
9.00	00900	HOUSEKEEPING	2,047,038	656,785	2,703,823	0	2,703,823	9.00
10.00	01000	DIETARY	3,074,633	3,455,106	6,529,739	-5,210,681	1,319,058	10.00
11.00	01100	CAFETERIA	0	0	0	5,210,681	5,210,681	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	220,719	220,719	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	643,107	3,856,156	4,499,263	0	4,499,263	14.00
15.00	01500	PHARMACY	4,161,967	32,816,000	36,977,967	-2,314	36,975,653	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,373,482	523,448	2,896,930	0	2,896,930	17.00
17.01	01701	INSERVICE EDUCATION	1,422,098	2,024,256	3,446,354	0	3,446,354	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,789,013	1,789,013	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,881,991	1,298,709	3,180,700	-1,789,013	1,391,687	22.00
23.00	02300	PARAMED ED PRGM	212,071	38,710	250,781	0	250,781	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,976,608	11,219,074	32,195,682	-437,654	31,758,028	30.00
31.00	03100	INTENSIVE CARE UNIT	3,385,039	2,440,435	5,825,474	0	5,825,474	31.00
40.00	04000	SUBPROVIDER - IPF	3,289,920	448,334	3,738,254	0	3,738,254	40.00
41.00	04100	SUBPROVIDER - IRF	1,506,466	405,397	1,911,863	0	1,911,863	41.00
43.00	04300	NURSERY	371,264	100,820	472,084	0	472,084	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,384,115	43,490,787	44,874,902	-12,114,505	32,760,397	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	703,560	287,986	991,546	-4,176	987,370	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,669,577	7,222,920	13,892,497	-142,328	13,750,169	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,890,765	8,791,490	10,682,255	-4,911,439	5,770,816	59.00
60.00	06000	LABORATORY	4,102,420	8,615,626	12,718,046	-37,423	12,680,623	60.00
65.00	06500	RESPIRATORY THERAPY	1,484,967	542,623	2,027,590	-835	2,026,755	65.00
66.00	06600	PHYSICAL THERAPY	6,573,684	1,579,584	8,153,268	-236,596	7,916,672	66.00
69.00	06900	ELECTROCARDIOLOGY	996,152	927,456	1,923,608	0	1,923,608	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	284,526	67,176	351,702	0	351,702	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	17,054,425	17,054,425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	783,130	783,130	0	783,130	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	340,145	92,323	432,468	-37,631	394,837	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,187,668	4,048,062	10,235,730	-412,040	9,823,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	1,842,260	425,137	2,267,397	-151,644	2,115,753	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	192,291	427,048	619,339	0	619,339	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		8,963,080	8,963,080	-8,963,080	0	113.00
116.00	11600	HOSPICE	962,914	1,178,642	2,141,556	388,639	2,530,195	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,609,668	169,697,989	256,307,657	15,848,665	272,156,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,040,760	9,040,760	-6,004,313	3,036,447	192.00
194.00	07950	RENTAL SPACE	0	14,296,864	14,296,864	-9,965,218	4,331,646	194.00
194.01	07951	FOUNDATION	168,683	426,236	594,919	0	594,919	194.01
194.02	07952	RETAIL SERVICES	134,943	29,244	164,187	0	164,187	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	308,304	308,304	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	786,620	786,620	-162,084	624,536	194.05
194.06	07956	VACANT SPACE	0	60,560	60,560	-25,354	35,206	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	86,913,294	194,338,273	281,251,567	0	281,251,567	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/8/2020 3:16 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	1,331,931	21,376,768		1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	6,215,457		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,946,752	17,249,719		4.00
5.01	00540	NONPATIENT TELEPHONES	0	0		5.01
5.02	00550	DATA PROCESSING	10,080,905	13,712,068		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	58,441		5.03
5.04	00570	ADMITTING	0	4,472,955		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	93,580		5.05
5.06	00590	OTHER A&G	9,260,213	29,680,071		5.06
7.00	00700	OPERATION OF PLANT	0	306,250		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	711,668		8.00
9.00	00900	HOUSEKEEPING	-109	2,703,714		9.00
10.00	01000	DIETARY	-15,794	1,303,264		10.00
11.00	01100	CAFETERIA	-3,945,629	1,265,052		11.00
13.00	01300	NURSING ADMINISTRATION	0	220,719		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,499,263		14.00
15.00	01500	PHARMACY	-215,440	36,760,213		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	2,896,930		17.00
17.01	01701	INSERVICE EDUCATION	-1,467,760	1,978,594		17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,789,013		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-947,705	443,982		22.00
23.00	02300	PARAMED ED PRGM	-68,434	182,347		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-6,491,036	25,266,992		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,825,474		31.00
40.00	04000	SUBPROVIDER - IPF	0	3,738,254		40.00
41.00	04100	SUBPROVIDER - IRF	-3,680	1,908,183		41.00
43.00	04300	NURSERY	0	472,084		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-9,637,323	23,123,074		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-225	987,145		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-202,068	13,548,101		54.00
59.00	05900	CARDIAC CATHETERIZATION	-1,081	5,769,735		59.00
60.00	06000	LABORATORY	-1,279,660	11,400,963		60.00
65.00	06500	RESPIRATORY THERAPY	-2,985	2,023,770		65.00
66.00	06600	PHYSICAL THERAPY	-102,124	7,814,548		66.00
69.00	06900	ELECTROCARDIOLOGY	-56,816	1,866,792		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,284	349,418		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	17,054,425		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	783,130		74.00
76.00	03950	ANCILLARY - OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-1,485	393,352		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,445,526	7,378,164		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	FAMILY PRACTICE	0	2,115,753		93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-427,479	191,860		96.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	-717	2,529,478		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,304,441	282,460,763		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,036,447		192.00
194.00	07950	RENTAL SPACE	0	4,331,646		194.00
194.01	07951	FOUNDATION	0	594,919		194.01
194.02	07952	RETAIL SERVICES	0	164,187		194.02
194.03	07953	REID CONTRACTED SERVICES	0	308,304		194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0		194.04
194.05	07955	CONNERSVILLE LOCATION	0	624,536		194.05
194.06	07956	VACANT SPACE	0	35,206		194.06
194.07	07957	HOME OFFICE	0	0		194.07
194.08	07958	CAMBRIDGE RHC	0	0		194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	10,304,441	291,556,008		200.00

RECLASSIFICATIONS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/8/2020 3:16 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAPITAL EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	10,889,775		1.00
2.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	5,965,094		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,941		3.00
4.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	243,387		4.00
5.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	190,041		5.00
6.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	6,976		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
	0		0	17,297,214		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	2,453,746	2,756,935		1.00
	0		2,453,746	2,756,935		
	C - LAUNDRY RECLASS					
1.00	REID CONTRACTED SERVICES	194.03	168,229	140,075		1.00
	0		168,229	140,075		
	D - NURSING VP RECLASS					
1.00	NURSING ADMINISTRATION	13.00	220,719	0		1.00
	0		220,719	0		
	E - OCCUPATIONAL MEDICINE RECLASS					
1.00	OTHER A&G	5.06	334,905	75,193		1.00
	0		334,905	75,193		
	F - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	17,054,425		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
	0		0	17,054,425		
	G - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	8,963,080		1.00
	0		0	8,963,080		
	J - INTERN AND RESIDENT					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	1,703,560	85,453		1.00
	0		1,703,560	85,453		
	N - HOSPICE					
1.00	HOSPICE	116.00	340,217	49,322		1.00
	TOTALS		340,217	49,322		
500.00	Grand Total: Increases		5,221,376	46,421,697		500.00

RECLASSIFICATIONS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/8/2020 3:16 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAPITAL EXPENSE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,113	9		1.00
2.00	ADMITTING	5.04	0	15,176	9		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	165,919	13		3.00
4.00	OTHER A&G	5.06	0	320,614	13		4.00
5.00	PHARMACY	15.00	0	2,314	10		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	44,304	10		6.00
7.00	OPERATING ROOM	50.00	0	6,278	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	115,556	0		8.00
9.00	LABORATORY	60.00	0	37,423	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	835	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	236,596	0		11.00
12.00	CARDIAC REHABILITATION	76.97	0	37,631	0		12.00
13.00	EMERGENCY	91.00	0	1,942	0		13.00
14.00	FAMILY PRACTICE	93.00	0	151,644	0		14.00
15.00	HOSPICE	116.00	0	900	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,004,313	0		16.00
17.00	RENTAL SPACE	194.00	0	9,965,218	0		17.00
18.00	CONNERSVILLE LOCATION	194.05	0	162,084	0		18.00
19.00	VACANT SPACE	194.06	0	25,354	0		19.00
	0		0	17,297,214			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	2,453,746	2,756,935	0		1.00
	0		2,453,746	2,756,935			
	C - LAUNDRY RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	168,229	140,075	0		1.00
	0		168,229	140,075			
	D - NURSING VP RECLASS						
1.00	OTHER A&G	5.06	220,719	0	0		1.00
	0		220,719	0			
	E - OCCUPATIONAL MEDICINE RECLASS						
1.00	EMERGENCY	91.00	334,905	75,193	0		1.00
	0		334,905	75,193			
	F - IMPLANTABLE DEVICES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	3,811	0		1.00
2.00	OPERATING ROOM	50.00	0	12,108,227	0		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	4,176	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26,772	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	4,911,439	0		5.00
	0		0	17,054,425			
	G - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	8,963,080	11		1.00
	0		0	8,963,080			
	J - INTERN AND RESIDENT						
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	1,703,560	85,453	0		1.00
	0		1,703,560	85,453			
	N - HOSPICE						
1.00	ADULTS & PEDIATRICS	30.00	340,217	49,322	0		1.00
	TOTALS		340,217	49,322			
500.00	Grand Total: Decreases		5,221,376	46,421,697			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 6/8/2020 3:16 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	14,477,094	1,804,345	0	1,804,345	0	1.00
2.00	Land Improvements	14,989,210	0	0	0	1,471,519	2.00
3.00	Buildings and Fixtures	297,210,638	14,121,351	0	14,121,351	0	3.00
4.00	Building Improvements	12,458,447	520,683	0	520,683	0	4.00
5.00	Fixed Equipment	2,182,235	0	0	0	1,427	5.00
6.00	Movable Equipment	182,552,200	0	0	0	10,298,095	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	523,869,824	16,446,379	0	16,446,379	11,771,041	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	523,869,824	16,446,379	0	16,446,379	11,771,041	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	16,281,439	0	1.00
2.00	Land Improvements	13,517,691	0	2.00
3.00	Buildings and Fixtures	311,331,989	0	3.00
4.00	Building Improvements	12,979,130	0	4.00
5.00	Fixed Equipment	2,180,808	0	5.00
6.00	Movable Equipment	172,254,105	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	528,545,162	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	528,545,162	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 6/8/2020 3:16 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	0	0	0	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	356,291,057	0	356,291,057	0.674098	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	172,254,105	0	172,254,105	0.325902	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	528,545,162	0	528,545,162	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	21,184,786	190,041	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	5,965,094	6,976	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	27,149,880	197,017	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	1,941	0	21,376,768	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	243,387	0	6,215,457	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	245,328	0	27,592,225	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/8/2020 3:16 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
1.01	Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter 2)		0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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)	B	0	PURCHASING RECEIVING AND STORES	5.03	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	-14,487,302			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	69,800,181			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-3,345,942	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	0	PURCHASING RECEIVING AND STORES	5.03	0	16.00
17.00	Sale of drugs to other than patients	B	-215,281	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-13,739	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP BLDG & FIXT - OFFSITE		0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/8/2020 3:16 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	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-599,687	CAFETERIA	11.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-239,493	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-345,181	DATA PROCESSING	5.02	0	33.02
33.03	MISCELLANEOUS INCOME	B	-106,085	OTHER A&G	5.06	0	33.03
33.04	MISCELLANEOUS INCOME	B	-1,560	OPERATING ROOM	50.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-2,985	RESPIRATORY THERAPY	65.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-62,272	INSERVICE EDUCATION	17.01	0	33.06
33.07	MISCELLANEOUS INCOME	B	-68,434	PARAMED ED PRGM	23.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-1,714	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-95,705	PHYSICAL THERAPY	66.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-190,400	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-14,550	LABORATORY	60.00	0	33.11
33.12	MISCELLANEOUS INCOME	B	-424,167	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-109	HOUSEKEEPING	9.00	0	33.13
33.14	INTEREST INCOME	B	-3,903,421	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.14
33.15	UNNECESSARY BORROWING	A	-5,059,659	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.15
33.16	SELF INSURANCE ADJUSTMENT	A	-12,870,408	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	MARKETING/ADVERTISING	A	-10,271	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	MARKETING/ADVERTISING	A	-21,155	OTHER A&G	5.06	0	33.18
33.19	MARKETING/ADVERTISING	A	-2,007	DIETARY	10.00	0	33.19
33.20	MARKETING/ADVERTISING	A	-41,297	INSERVICE EDUCATION	17.01	0	33.20
33.21	MARKETING/ADVERTISING	A	-107	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.21
33.22	MARKETING/ADVERTISING	A	-12,897	ADULTS & PEDIATRICS	30.00	0	33.22
33.23	MARKETING/ADVERTISING	A	-3,623	SUBPROVIDER - IRF	41.00	0	33.23
33.24	MARKETING/ADVERTISING	A	-736	RADIOLOGY-DIAGNOSTIC	54.00	0	33.24
33.25	MARKETING/ADVERTISING	A	-1,081	CARDIAC CATHETERIZATION	59.00	0	33.25
33.26	MARKETING/ADVERTISING	A	-4,197	PHYSICAL THERAPY	66.00	0	33.26
33.27	MARKETING/ADVERTISING	A	-2,284	ELECTROENCEPHALOGRAPHY	70.00	0	33.27
33.28	MARKETING/ADVERTISING	A	-1,485	CARDIAC REHABILITATION	76.97	0	33.28
33.29	MARKETING/ADVERTISING	A	-77,105	EMERGENCY	91.00	0	33.29
33.30	MARKETING/ADVERTISING	A	-3,312	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.30
33.31	NON-ALLOWABLE EXPENSES	A	-1,024,393	OTHER A&G	5.06	0	33.31
33.32	NON-ALLOWABLE EXPENSES	A	-48	DIETARY	10.00	0	33.32
33.33	NON-ALLOWABLE EXPENSES	A	-1,287,543	INSERVICE EDUCATION	17.01	0	33.33
33.34	NON-ALLOWABLE EXPENSES	A	-90	ADULTS & PEDIATRICS	30.00	0	33.34
33.35	NON-ALLOWABLE EXPENSES	A	-57	SUBPROVIDER - IRF	41.00	0	33.35
33.36	NON-ALLOWABLE EXPENSES	A	-164	OPERATING ROOM	50.00	0	33.36
33.37	NON-ALLOWABLE EXPENSES	A	-225	DELIVERY ROOM & LABOR ROOM	52.00	0	33.37
33.38	NON-ALLOWABLE EXPENSES	A	-2,222	PHYSICAL THERAPY	66.00	0	33.38
33.39	NON-ALLOWABLE EXPENSES	A	-7,698	EMERGENCY	91.00	0	33.39
33.40	NON-ALLOWABLE EXPENSES	A	-717	HOSPICE	116.00	0	33.40
33.41	HAF EXPENSE	A	-14,904,737	OTHER A&G	5.06	0	33.41
33.42	BOND REFUNDING - 2015 BONDS	A	401,531	OTHER A&G	5.06	0	33.42
33.43	BOND REFUNDING - 2016 BONDS	A	7,737	OTHER A&G	5.06	0	33.43
33.44	OCC MED - EMPLOYEE COST	A	-53,169	EMERGENCY	91.00	0	33.44
33.45	OCC MED - EMPLOYEE COST	A	-159	PHARMACY	15.00	0	33.45
33.46	OCC MED - EMPLOYEE COST	A	-3,972	RADIOLOGY-DIAGNOSTIC	54.00	0	33.46
33.47	OCC MED - EMPLOYEE COST	A	-390,163	LABORATORY	60.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		10,304,441				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/8/2020 3:16 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	21,547,740	27,442,895	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	NEW CAPITAL	10,295,011	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS & HR	30,066,924	0	3.00
4.00	5.02	DATA PROCESSING	INFORMATION SYSTEMS	10,426,086	0	4.00
4.01	5.06	OTHER A&G	A&G	24,907,315	0	4.01
4.02	0.00			0	0	4.02
5.00	0		0	97,243,076	27,442,895	5.00

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

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

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

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

6.00	A	REID O/P SURGER	55.00		0.00	6.00
7.00	B		0.00	REID HOME OFFIC	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/8/2020 3:16 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-5,895,155	0		1.00
2.00	10,295,011	9		2.00
3.00	30,066,924	0		3.00
4.00	10,426,086	0		4.00
4.01	24,907,315	0		4.01
4.02	0	0		4.02
5.00	69,800,181			5.00

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

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

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

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

6.00			6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/8/2020 3:16 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	17.01	INSERVICE EDUCATION	148,678	23,131	125,547	179,000	837	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	947,598	947,598	0	197,500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	6,476,335	6,476,335	0	179,000	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	179,000	0	4.00
5.00	50.00	OPERATING ROOM	3,740,444	3,740,444	0	246,400	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	6,960	6,960	0	260,300	0	6.00
7.00	60.00	LABORATORY	874,947	874,947	0	260,300	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	56,816	56,816	0	179,000	0	8.00
9.00	91.00	EMERGENCY	2,307,554	2,307,554	0	179,000	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			14,559,332	14,433,785	125,547		837	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	17.01	INSERVICE EDUCATION	72,030	3,602	0	0	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	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			72,030	3,602	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	17.01	INSERVICE EDUCATION	0	72,030	53,517	76,648		1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	947,598		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	6,476,335		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0		4.00
5.00	50.00	OPERATING ROOM	0	0	0	3,740,444		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	6,960		6.00
7.00	60.00	LABORATORY	0	0	0	874,947		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	56,816		8.00
9.00	91.00	EMERGENCY	0	0	0	2,307,554		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	72,030	53,517	14,487,302		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	21,376,768	21,376,768				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	6,215,457	0	6,215,457			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	17,249,719	0	9,026	0	17,258,745	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	13,712,068	81,099	24,708	0	47,151	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	58,441	217,154	0	0	8,137	5.03
5.04	00570	ADMITTING	4,472,955	11,309	42,511	0	614,495	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	93,580	0	176,452	0	0	5.05
5.06	00590	OTHER A&G	29,680,071	96,717	15,434	0	654,085	5.06
7.00	00700	OPERATION OF PLANT	306,250	269,368	35,155	0	65,293	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	711,668	301,950	0	0	69,336	8.00
9.00	00900	HOUSEKEEPING	2,703,714	199,701	0	0	407,770	9.00
10.00	01000	DIETARY	1,303,264	451,958	0	0	123,681	10.00
11.00	01100	CAFETERIA	1,265,052	231,597	0	0	488,786	11.00
13.00	01300	NURSING ADMINISTRATION	220,719	47,857	0	0	43,967	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,499,263	205,894	0	0	128,107	14.00
15.00	01500	PHARMACY	36,760,213	241,633	0	0	829,064	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	106,525	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,896,930	30,379	0	0	472,798	17.00
17.01	01701	INSERVICE EDUCATION	1,978,594	254,803	0	0	283,282	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,789,013	0	0	0	339,349	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	443,982	0	0	0	35,543	22.00
23.00	02300	PARAMED ED PRGM	182,347	25,972	60,472	0	42,245	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,266,992	2,860,726	0	0	4,110,792	30.00
31.00	03100	INTENSIVE CARE UNIT	5,825,474	601,011	0	0	674,300	31.00
40.00	04000	SUBPROVIDER - IPF	3,738,254	546,863	0	0	655,352	40.00
41.00	04100	SUBPROVIDER - IRF	1,908,183	438,127	0	0	300,088	41.00
43.00	04300	NURSERY	472,084	65,628	0	0	73,956	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,123,074	1,117,765	295,387	0	275,716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	987,145	203,568	0	0	140,149	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,548,101	1,731,652	36,103	0	1,328,580	54.00
59.00	05900	CARDIAC CATHETERIZATION	5,769,735	332,402	0	0	376,640	59.00
60.00	06000	LABORATORY	11,400,963	712,220	0	0	817,202	60.00
65.00	06500	RESPIRATORY THERAPY	2,023,770	40,317	0	0	295,805	65.00
66.00	06600	PHYSICAL THERAPY	7,814,548	197,889	954,825	0	1,309,478	66.00
69.00	06900	ELECTROCARDIOLOGY	1,866,792	171,623	0	0	198,433	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	349,418	0	87,820	0	56,678	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	17,054,425	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	783,130	36,474	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	393,352	200,361	0	0	67,757	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,378,164	757,922	0	0	1,165,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	2,115,753	0	19,112	0	366,978	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	191,860	43,426	64,804	0	38,304	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,529,478	10,893	0	0	259,584	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	282,460,763	12,736,258	1,928,334	0	17,164,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,036,447	0	2,440,833	0	0	192.00
194.00	07950	RENTAL SPACE	4,331,646	0	440,678	0	0	194.00
194.01	07951	FOUNDATION	594,919	5,043	0	0	33,602	194.01
194.02	07952	RETAIL SERVICES	164,187	57,281	0	0	26,881	194.02
194.03	07953	REID CONTRACTED SERVICES	308,304	0	0	0	33,511	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	7,040	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	624,536	0	0	0	0	194.05
194.06	07956	VACANT SPACE	35,206	1,731,970	387,382	0	0	194.06
194.07	07957	HOME OFFICE	0	6,846,216	1,011,190	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	291,556,008	21,376,768	6,215,457	0	17,258,745	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	13,865,026				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	18,340	302,072			5.03
5.04	00570	ADMITTING	0	907,829	560	6,049,659		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	270,032	5.05
5.06	00590	OTHER A&G	0	559,369	857	0	0	5.06
7.00	00700	OPERATION OF PLANT	0	45,850	496	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,340	38	0	0	8.00
9.00	00900	HOUSEKEEPING	0	27,510	193	0	0	9.00
10.00	01000	DIETARY	0	394,310	3,278	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100,870	36,519	0	0	14.00
15.00	01500	PHARMACY	0	504,349	33,818	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	247,590	1,056	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	605,219	1	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	247,590	68	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	119,210	52	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,540,085	29,082	346,018	15,434	30.00
31.00	03100	INTENSIVE CARE UNIT	0	394,310	10,082	59,677	2,662	31.00
40.00	04000	SUBPROVIDER - IPF	0	146,720	3,000	63,715	2,842	40.00
41.00	04100	SUBPROVIDER - IRF	0	320,950	2,196	29,831	1,331	41.00
43.00	04300	NURSERY	0	0	1,935	11,767	525	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,036,209	55,033	1,065,534	47,716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	256,760	4,194	61,217	2,731	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,109,569	46,861	888,531	39,633	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	210,910	23,182	675,262	30,120	59.00
60.00	06000	LABORATORY	0	871,149	5,286	635,778	28,359	60.00
65.00	06500	RESPIRATORY THERAPY	0	119,210	11,180	168,057	7,496	65.00
66.00	06600	PHYSICAL THERAPY	0	1,063,719	1,929	134,363	5,993	66.00
69.00	06900	ELECTROCARDIOLOGY	0	311,780	2,389	209,981	9,366	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	155,890	608	28,300	1,262	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	198,211	8,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	811,321	36,189	73.00
74.00	07400	RENAL DIALYSIS	0	27,510	650	7,729	345	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	64,190	331	8,407	375	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,017,869	13,313	566,402	25,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	91,700	2,383	41,214	1,838	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	73,360	5,230	2,967	132	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	210,910	4,944	35,377	1,578	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	13,819,176	300,744	6,049,659	270,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	100	0	0	192.00
194.00	07950	RENTAL SPACE	0	45,850	770	0	0	194.00
194.01	07951	FOUNDATION	0	0	383	0	0	194.01
194.02	07952	RETAIL SERVICES	0	0	75	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
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)	0	13,865,026	302,072	6,049,659	270,032	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.05	5.06	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	31,006,533	31,006,533				5.06
7.00	00700	OPERATION OF PLANT	722,412	85,970	808,382			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,101,332	131,063	10,447	1,242,842		8.00
9.00	00900	HOUSEKEEPING	3,338,888	397,341	6,667	0	3,742,896	9.00
10.00	01000	DIETARY	2,276,491	270,912	15,637	0	232,071	10.00
11.00	01100	CAFETERIA	1,985,435	236,275	8,013	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	312,543	37,194	1,656	0	5,350	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,970,653	591,528	7,124	0	46,815	14.00
15.00	01500	PHARMACY	38,369,077	4,566,176	8,164	0	71,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	106,525	12,677	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,648,753	434,216	371	0	28,758	17.00
17.01	01701	INSERVICE EDUCATION	3,121,899	371,518	7,895	0	38,790	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,128,362	253,284	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	727,183	86,538	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	430,298	51,207	2,377	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,169,129	4,185,267	98,039	373,298	1,243,954	30.00
31.00	03100	INTENSIVE CARE UNIT	7,567,516	900,565	20,794	76,160	229,730	31.00
40.00	04000	SUBPROVIDER - IPF	5,156,746	613,673	18,921	86,243	237,087	40.00
41.00	04100	SUBPROVIDER - IRF	3,000,706	357,096	15,158	35,738	111,020	41.00
43.00	04300	NURSERY	625,895	74,484	2,271	0	9,363	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,016,434	3,215,064	34,406	189,138	344,762	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,655,764	197,043	7,043	66,837	76,911	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,729,030	2,228,829	45,633	121,778	213,345	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,418,251	882,802	3,890	67,417	50,159	59.00
60.00	06000	LABORATORY	14,470,957	1,722,102	17,103	0	180,240	60.00
65.00	06500	RESPIRATORY THERAPY	2,665,835	317,245	1,011	0	33,440	65.00
66.00	06600	PHYSICAL THERAPY	11,482,744	1,366,492	40,839	11,865	29,427	66.00
69.00	06900	ELECTROCARDIOLOGY	2,770,364	329,684	472	0	50,159	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	679,976	80,920	4,573	5,034	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	17,261,477	2,054,185	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	847,510	100,857	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	855,838	101,848	1,262	0	52,166	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	734,773	87,441	3,101	0	13,376	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,924,804	1,300,095	26,223	172,423	299,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	FAMILY PRACTICE	2,638,978	314,049	0	36,911	80,255	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	420,083	49,992	3,178	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,052,764	363,291	0	0	57,182	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269,391,958	28,368,923	412,268	1,242,842	3,736,208	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,477,380	651,830	91,615	0	0	192.00
194.00	07950	RENTAL SPACE	4,818,944	573,474	19,412	0	0	194.00
194.01	07951	FOUNDATION	633,947	75,442	174	0	3,344	194.01
194.02	07952	RETAIL SERVICES	248,424	29,563	579	0	3,344	194.02
194.03	07953	REID CONTRACTED SERVICES	341,815	40,677	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	7,040	838	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	624,536	74,322	0	0	0	194.05
194.06	07956	VACANT SPACE	2,154,558	256,401	78,795	0	0	194.06
194.07	07957	HOME OFFICE	7,857,406	935,063	205,539	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	291,556,008	31,006,533	808,382	1,242,842	3,742,896	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,795,111					10.00
11.00	01100	CAFETERIA	0	2,229,723				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,910	358,653			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,605	0	5,651,725		14.00
15.00	01500	PHARMACY	0	112,160	0	1,822	43,129,294	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	65,676	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	41,527	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	33,173	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	5,916	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	4,900	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,883,531	637,385	161,233	15,508	8,017	30.00
31.00	03100	INTENSIVE CARE UNIT	258,030	91,804	23,222	14,150	469	31.00
40.00	04000	SUBPROVIDER - IPF	445,471	110,103	27,851	520	802	40.00
41.00	04100	SUBPROVIDER - IRF	208,079	44,709	11,309	2,039	51	41.00
43.00	04300	NURSERY	0	8,699	2,200	862	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,597	11,281	2,729,944	122,350	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,111	4,075	12,386	950	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	186,072	47,068	25,814	909,902	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	51,685	13,074	2,305,297	394	59.00
60.00	06000	LABORATORY	0	152,574	0	446,558	81	60.00
65.00	06500	RESPIRATORY THERAPY	0	44,440	11,241	3,944	14	65.00
66.00	06600	PHYSICAL THERAPY	0	177,169	0	245	643	66.00
69.00	06900	ELECTROCARDIOLOGY	0	31,120	0	16,362	305,398	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,893	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	1,677	424	0	41,600,955	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	35	33	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	12,471	3,155	40	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	168,094	42,520	7,779	32,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	63,912	0	0	33	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	9,727	0	67,793	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	42,424	0	627	146,907	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,795,111	2,206,533	358,653	5,651,725	43,129,294	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	6,388	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	6,733	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	10,069	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
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)	2,795,111	2,229,723	358,653	5,651,725	43,129,294	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
			16.00	17.00	17.01	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	119,202					16.00
17.00	01700	SOCIAL SERVICE	0	4,177,774				17.00
17.01	01701	INSERVICE EDUCATION	0	0	3,581,629			17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	2,414,819		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		819,637	22.00
23.00	02300	PARAMED ED PRGM	0	0	8,586			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,842	3,060,633	1,143,717	1,875,937	636,729	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	232,283	160,193	195,247	66,271	31.00
40.00	04000	SUBPROVIDER - IPF	1,260	0	192,276	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	590	0	78,628	0	0	41.00
43.00	04300	NURSERY	233	0	15,138	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,649	0	250,795	123,396	41,883	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,210	49,845	32,084	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,569	0	334,168	26,554	9,013	54.00
59.00	05900	CARDIAC CATHETERIZATION	13,352	0	90,377	0	0	59.00
60.00	06000	LABORATORY	12,571	0	269,774	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,323	0	77,724	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,657	0	313,607	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,152	0	59,875	64,041	21,737	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	560	0	18,753	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	3,919	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,042	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	153	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	166	0	21,464	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,200	835,013	311,348	129,644	44,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	815	0	111,163	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	59	0	16,946	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	700	0	52,193			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	119,202	4,177,774	3,558,809	2,414,819	819,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	11,071	0	0	194.01
194.02	07952	RETAIL SERVICES	0	0	11,749	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
		16.00	17.00	17.01	21.00	22.00	
202.00	TOTAL (sum lines 118 through 201)	119,202	4,177,774	3,581,629	2,414,819	819,637	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	INSERVICE EDUCATION						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM	497,368					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	50,499,219	-2,512,666	47,986,553		30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,837,614	-261,518	9,576,096		31.00
40.00	04000	SUBPROVIDER - IPF	0	6,890,953	0	6,890,953		40.00
41.00	04100	SUBPROVIDER - IRF	0	3,865,123	0	3,865,123		41.00
43.00	04300	NURSERY	0	739,145	0	739,145		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,144,699	-165,279	33,979,420		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,120,259	0	2,120,259		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,368	23,392,143	-35,567	23,356,576		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,896,698	0	10,896,698		59.00
60.00	06000	LABORATORY	0	17,271,960	0	17,271,960		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,158,217	0	3,158,217		65.00
66.00	06600	PHYSICAL THERAPY	0	13,425,688	0	13,425,688		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,653,364	-85,778	3,567,586		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	800,709	0	800,709		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	19,319,581	0	19,319,581		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,567,465	0	42,567,465		73.00
74.00	07400	RENAL DIALYSIS	0	1,011,335	0	1,011,335		74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	875,987	0	875,987		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,305,395	-173,648	14,131,747		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	FAMILY PRACTICE	0	3,246,116	0	3,246,116		93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	567,778	0	567,778		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,716,088	0	3,716,088		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	497,368	266,305,536	-3,234,456	263,071,080		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	6,220,825	0	6,220,825		192.00
194.00	07950	RENTAL SPACE	0	5,411,830	0	5,411,830		194.00
194.01	07951	FOUNDATION	0	730,366	0	730,366		194.01
194.02	07952	RETAIL SERVICES	0	300,392	0	300,392		194.02
194.03	07953	REID CONTRACTED SERVICES	0	392,561	0	392,561		194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	7,878	0	7,878		194.04
194.05	07955	CONNERSVILLE LOCATION	0	698,858	0	698,858		194.05
194.06	07956	VACANT SPACE	0	2,489,754	0	2,489,754		194.06
194.07	07957	HOME OFFICE	0	8,998,008	0	8,998,008		194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0		194.08
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	497,368	291,556,008	-3,234,456	288,321,552		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	410	0	9,026	0	9,436	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	237,189	81,099	24,708	0	342,996	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	4,036	217,154	0	0	221,190	5.03
5.04	00570	ADMITTING	9,237	11,309	42,511	0	63,057	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5,462	0	176,452	0	181,914	5.05
5.06	00590	OTHER A&G	14,664	96,717	15,434	0	126,815	5.06
7.00	00700	OPERATION OF PLANT	21,264	269,368	35,155	0	325,787	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,127	301,950	0	0	360,077	8.00
9.00	00900	HOUSEKEEPING	36,170	199,701	0	0	235,871	9.00
10.00	01000	DIETARY	67,865	451,958	0	0	519,823	10.00
11.00	01100	CAFETERIA	0	231,597	0	0	231,597	11.00
13.00	01300	NURSING ADMINISTRATION	0	47,857	0	0	47,857	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	256,066	205,894	0	0	461,960	14.00
15.00	01500	PHARMACY	323,411	241,633	0	0	565,044	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	106,525	0	106,525	16.00
17.00	01700	SOCIAL SERVICE	24,026	30,379	0	0	54,405	17.00
17.01	01701	INSERVICE EDUCATION	0	254,803	0	0	254,803	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	28,504	0	0	0	28,504	22.00
23.00	02300	PARAMED ED PRGM	1,417	25,972	60,472	0	87,861	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	572,841	2,860,726	0	0	3,433,567	30.00
31.00	03100	INTENSIVE CARE UNIT	491,038	601,011	0	0	1,092,049	31.00
40.00	04000	SUBPROVIDER - IPF	27,896	546,863	0	0	574,759	40.00
41.00	04100	SUBPROVIDER - IRF	45,246	438,127	0	0	483,373	41.00
43.00	04300	NURSERY	6,616	65,628	0	0	72,244	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	994,297	1,117,765	295,387	0	2,407,449	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,670	203,568	0	0	241,238	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,022,461	1,731,652	36,103	0	2,790,216	54.00
59.00	05900	CARDIAC CATHETERIZATION	239,355	332,402	0	0	571,757	59.00
60.00	06000	LABORATORY	485,054	712,220	0	0	1,197,274	60.00
65.00	06500	RESPIRATORY THERAPY	56,352	40,317	0	0	96,669	65.00
66.00	06600	PHYSICAL THERAPY	107,388	197,889	954,825	0	1,260,102	66.00
69.00	06900	ELECTROCARDIOLOGY	99,209	171,623	0	0	270,832	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,824	0	87,820	0	106,644	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
74.00	07400	RENAL DIALYSIS	9,941	36,474	0	0	46,415	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,432	200,361	0	0	207,793	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	272,117	757,922	0	0	1,030,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	FAMILY PRACTICE	23,853	0	19,112	0	42,965	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,590	43,426	64,804	0	109,820	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	650	10,893	0	0	11,543	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,607,678	12,736,258	1,928,334	0	20,272,270	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	111,234	0	2,440,833	0	2,552,067	192.00
194.00	07950	RENTAL SPACE	100,462	0	440,678	0	541,140	194.00
194.01	07951	FOUNDATION	1,246	5,043	0	0	6,289	194.01
194.02	07952	RETAIL SERVICES	343	57,281	0	0	57,624	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	7,040	0	7,040	194.04
194.05	07955	CONNERSVILLE LOCATION	31,802	0	0	0	31,802	194.05
194.06	07956	VACANT SPACE	0	1,731,970	387,382	0	2,119,352	194.06
194.07	07957	HOME OFFICE	0	6,846,216	1,011,190	0	7,857,406	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments					0	200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	5,852,765	21,376,768	6,215,457	0	33,444,990	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,436					4.00
5.01	00540	NONPATIENT TELEPHONES	0	0				5.01
5.02	00550	DATA PROCESSING	26	0	343,022			5.02
5.03	00560	PURCHASING RECEIVING AND STORES	4	0	454	221,648		5.03
5.04	00570	ADMITTING	336	0	22,460	411	86,264	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	OTHER A&G	358	0	13,839	629	0	5.06
7.00	00700	OPERATION OF PLANT	36	0	1,134	364	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38	0	454	28	0	8.00
9.00	00900	HOUSEKEEPING	223	0	681	142	0	9.00
10.00	01000	DIETARY	68	0	9,755	2,405	0	10.00
11.00	01100	CAFETERIA	267	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	24	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70	0	2,496	26,796	0	14.00
15.00	01500	PHARMACY	454	0	12,478	24,814	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	259	0	6,125	775	0	17.00
17.01	01701	INSERVICE EDUCATION	155	0	14,973	1	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	186	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	19	0	6,125	50	0	22.00
23.00	02300	PARAMED ED PRGM	23	0	2,949	38	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,241	0	62,842	21,339	4,933	30.00
31.00	03100	INTENSIVE CARE UNIT	369	0	9,755	7,398	851	31.00
40.00	04000	SUBPROVIDER - IPF	359	0	3,630	2,201	908	40.00
41.00	04100	SUBPROVIDER - IRF	164	0	7,940	1,611	425	41.00
43.00	04300	NURSERY	40	0	0	1,420	168	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151	0	25,636	40,378	15,215	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77	0	6,352	3,077	873	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	727	0	27,451	34,385	12,666	54.00
59.00	05900	CARDIAC CATHETERIZATION	206	0	5,218	17,010	9,626	59.00
60.00	06000	LABORATORY	447	0	21,552	3,878	9,063	60.00
65.00	06500	RESPIRATORY THERAPY	162	0	2,949	8,204	2,396	65.00
66.00	06600	PHYSICAL THERAPY	717	0	26,317	1,416	1,915	66.00
69.00	06900	ELECTROCARDIOLOGY	109	0	7,713	1,753	2,993	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31	0	3,857	446	403	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	2,826	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,565	73.00
74.00	07400	RENAL DIALYSIS	0	0	681	477	110	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	37	0	1,588	243	120	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	638	0	25,182	9,769	8,074	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	201	0	2,269	1,749	588	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	21	0	1,815	3,838	42	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	142	0	5,218	3,628	504	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,385	0	341,888	220,673	86,264	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	74	0	192.00
194.00	07950	RENTAL SPACE	0	0	1,134	565	0	194.00
194.01	07951	FOUNDATION	18	0	0	281	0	194.01
194.02	07952	RETAIL SERVICES	15	0	0	55	0	194.02
194.03	07953	REID CONTRACTED SERVICES	18	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
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)	9,436	0	343,022	221,648	86,264	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.05	5.06	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	181,914					5.05
5.06	00590	OTHER A&G	0	141,641				5.06
7.00	00700	OPERATION OF PLANT	0	393	327,714			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	599	4,235	365,431		8.00
9.00	00900	HOUSEKEEPING	0	1,816	2,703	0	241,436	9.00
10.00	01000	DIETARY	0	1,238	6,339	0	14,970	10.00
11.00	01100	CAFETERIA	0	1,080	3,248	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	170	671	0	345	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,704	2,888	0	3,020	14.00
15.00	01500	PHARMACY	0	20,773	3,310	0	4,638	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	58	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,985	150	0	1,855	17.00
17.01	01701	INSERVICE EDUCATION	0	1,698	3,201	0	2,502	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,158	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	396	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	234	964	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,395	19,132	39,745	109,760	80,239	30.00
31.00	03100	INTENSIVE CARE UNIT	1,793	4,117	8,430	22,393	14,819	31.00
40.00	04000	SUBPROVIDER - IPF	1,914	2,805	7,670	25,358	15,293	40.00
41.00	04100	SUBPROVIDER - IRF	896	1,632	6,145	10,508	7,161	41.00
43.00	04300	NURSERY	354	340	921	0	604	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,177	14,697	13,948	55,612	22,239	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,839	901	2,855	19,652	4,961	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,694	10,189	18,499	35,806	13,762	54.00
59.00	05900	CARDIAC CATHETERIZATION	20,287	4,036	1,577	19,823	3,236	59.00
60.00	06000	LABORATORY	19,101	7,872	6,933	0	11,626	60.00
65.00	06500	RESPIRATORY THERAPY	5,049	1,450	410	0	2,157	65.00
66.00	06600	PHYSICAL THERAPY	4,037	6,247	16,556	3,489	1,898	66.00
69.00	06900	ELECTROCARDIOLOGY	6,308	1,507	191	0	3,236	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	850	370	1,854	1,480	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	5,955	9,390	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,374	461	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	232	466	512	0	3,365	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	253	400	1,257	0	863	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,016	5,943	10,631	50,697	19,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	1,238	1,436	0	10,853	5,177	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	89	229	1,288	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,063	1,661	0	0	3,689	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,914	129,583	167,131	365,431	241,004	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,980	37,140	0	0	192.00
194.00	07950	RENTAL SPACE	0	2,622	7,869	0	0	194.00
194.01	07951	FOUNDATION	0	345	71	0	216	194.01
194.02	07952	RETAIL SERVICES	0	135	235	0	216	194.02
194.03	07953	REID CONTRACTED SERVICES	0	186	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	4	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	340	0	0	0	194.05
194.06	07956	VACANT SPACE	0	1,172	31,943	0	0	194.06
194.07	07957	HOME OFFICE	0	4,274	83,325	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
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)	181,914	141,641	327,714	365,431	241,436	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	554,598					10.00
11.00	01100	CAFETERIA	0	236,192				11.00
13.00	01300	NURSING ADMINISTRATION	0	202	49,269			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,772	0	503,706		14.00
15.00	01500	PHARMACY	0	11,881	0	162	643,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,957	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	4,399	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	3,514	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	627	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	519	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	373,725	67,516	22,149	1,382	120	30.00
31.00	03100	INTENSIVE CARE UNIT	51,198	9,725	3,190	1,261	7	31.00
40.00	04000	SUBPROVIDER - IPF	88,389	11,663	3,826	46	12	40.00
41.00	04100	SUBPROVIDER - IRF	41,286	4,736	1,554	182	1	41.00
43.00	04300	NURSERY	0	921	302	77	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,724	1,550	243,301	1,826	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,707	560	1,104	14	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,710	6,466	2,301	13,577	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,475	1,796	205,460	6	59.00
60.00	06000	LABORATORY	0	16,162	0	39,800	1	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,708	1,544	352	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,767	0	22	10	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,297	0	1,458	4,557	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,154	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	178	58	0	620,749	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,321	433	4	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	17,806	5,841	693	482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	6,770	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,030	0	6,042	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	4,494	0	56	2,192	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	554,598	233,735	49,269	503,706	643,554	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	677	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	713	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	1,067	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
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)	554,598	236,192	49,269	503,706	643,554	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
			16.00	17.00	17.01	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	106,583					16.00
17.00	01700	SOCIAL SERVICE	0	72,511				17.00
17.01	01701	INSERVICE EDUCATION	0	0	281,732			17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	4,858		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		35,721	22.00
23.00	02300	PARAMED ED PRGM	0	0	675			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,099	53,121	89,964			30.00
31.00	03100	INTENSIVE CARE UNIT	1,052	4,032	12,601			31.00
40.00	04000	SUBPROVIDER - IPF	1,123	0	15,125			40.00
41.00	04100	SUBPROVIDER - IRF	526	0	6,185			41.00
43.00	04300	NURSERY	207	0	1,191			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,730	0	19,728			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,079	865	2,524			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,662	0	26,286			54.00
59.00	05900	CARDIAC CATHETERIZATION	11,903	0	7,109			59.00
60.00	06000	LABORATORY	11,207	0	21,221			60.00
65.00	06500	RESPIRATORY THERAPY	2,962	0	6,114			65.00
66.00	06600	PHYSICAL THERAPY	2,368	0	24,668			66.00
69.00	06900	ELECTROCARDIOLOGY	3,701	0	4,710			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	499	0	1,475			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,494	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,301	0	0			73.00
74.00	07400	RENAL DIALYSIS	136	0	0			74.00
76.00	03950	ANCILLARY - OTHER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	148	0	1,688			76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,984	14,493	24,491			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	726	0	8,744			93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	52	0	1,333			96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	624	0	4,105			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,583	72,511	279,937	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	RENTAL SPACE	0	0	0			194.00
194.01	07951	FOUNDATION	0	0	871			194.01
194.02	07952	RETAIL SERVICES	0	0	924			194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0			194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0			194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0			194.05
194.06	07956	VACANT SPACE	0	0	0			194.06
194.07	07957	HOME OFFICE	0	0	0			194.07
194.08	07958	CAMBRIDGE RHC	0	0	0			194.08
200.00		Cross Foot Adjustments				4,858	35,721	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
		16.00	17.00	17.01	21.00	22.00	
202.00	TOTAL (sum lines 118 through 201)	106,583	72,511	281,732	4,858	35,721	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	INSERVICE EDUCATION						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM	93,263					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,398,269	0	4,398,269		30.00
31.00	03100	INTENSIVE CARE UNIT		1,245,040	0	1,245,040		31.00
40.00	04000	SUBPROVIDER - IPF		755,081	0	755,081		40.00
41.00	04100	SUBPROVIDER - IRF		574,325	0	574,325		41.00
43.00	04300	NURSERY		78,789	0	78,789		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,917,361	0	2,917,361		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		289,678	0	289,678		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		3,054,397	0	3,054,397		54.00
59.00	05900	CARDIAC CATHETERIZATION		884,525	0	884,525		59.00
60.00	06000	LABORATORY		1,366,137	0	1,366,137		60.00
65.00	06500	RESPIRATORY THERAPY		135,126	0	135,126		65.00
66.00	06600	PHYSICAL THERAPY		1,368,529	0	1,368,529		66.00
69.00	06900	ELECTROCARDIOLOGY		312,365	0	312,365		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		119,063	0	119,063		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		21,665	0	21,665		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		671,686	0	671,686		73.00
74.00	07400	RENAL DIALYSIS		52,397	0	52,397		74.00
76.00	03950	ANCILLARY - OTHER		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		216,148	0	216,148		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY		1,251,128	0	1,251,128		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	FAMILY PRACTICE		82,716	0	82,716		93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		125,599	0	125,599		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE		38,919	0	38,919		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,958,943	0	19,958,943		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,592,261	0	2,592,261		192.00
194.00	07950	RENTAL SPACE		553,330	0	553,330		194.00
194.01	07951	FOUNDATION		8,768	0	8,768		194.01
194.02	07952	RETAIL SERVICES		59,917	0	59,917		194.02
194.03	07953	REID CONTRACTED SERVICES		1,271	0	1,271		194.03
194.04	07954	REID PHYSICIAN ASSOC.		7,044	0	7,044		194.04
194.05	07955	CONNERSVILLE LOCATION		32,142	0	32,142		194.05
194.06	07956	VACANT SPACE		2,152,467	0	2,152,467		194.06
194.07	07957	HOME OFFICE		7,945,005	0	7,945,005		194.07
194.08	07958	CAMBRIDGE RHC		0	0	0		194.08
200.00		Cross Foot Adjustments	93,263	133,842	0	133,842		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	93,263	33,444,990	0	33,444,990		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	873,266					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	275,457				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	400	0	86,640,168		4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	3,313	1,095	0	236,700	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	8,871	0	0	40,848	0	5.03
5.04	00570	ADMITTING	462	1,884	0	3,084,816	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,820	0	0	0	5.05
5.06	00590	OTHER A&G	3,951	684	0	3,283,559	0	5.06
7.00	00700	OPERATION OF PLANT	11,004	1,558	0	327,775	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,335	0	0	348,073	0	8.00
9.00	00900	HOUSEKEEPING	8,158	0	0	2,047,038	0	9.00
10.00	01000	DIETARY	18,463	0	0	620,887	0	10.00
11.00	01100	CAFETERIA	9,461	0	0	2,453,746	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,955	0	0	220,719	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,411	0	0	643,107	0	14.00
15.00	01500	PHARMACY	9,871	0	0	4,161,967	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,721	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,241	0	0	2,373,482	0	17.00
17.01	01701	INSERVICE EDUCATION	10,409	0	0	1,422,098	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,703,560	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	178,431	0	22.00
23.00	02300	PARAMED ED PRGM	1,061	2,680	0	212,071	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,864	0	0	20,636,391	0	30.00
31.00	03100	INTENSIVE CARE UNIT	24,552	0	0	3,385,039	0	31.00
40.00	04000	SUBPROVIDER - IPF	22,340	0	0	3,289,920	0	40.00
41.00	04100	SUBPROVIDER - IRF	17,898	0	0	1,506,466	0	41.00
43.00	04300	NURSERY	2,681	0	0	371,264	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,662	13,091	0	1,384,115	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,316	0	0	703,560	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,740	1,600	0	6,669,577	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	13,579	0	0	1,890,765	0	59.00
60.00	06000	LABORATORY	29,095	0	0	4,102,420	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,484,967	0	65.00
66.00	06600	PHYSICAL THERAPY	8,084	42,316	0	6,573,684	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,011	0	0	996,152	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,892	0	284,526	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
74.00	07400	RENAL DIALYSIS	1,490	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,185	0	0	340,145	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	30,962	0	0	5,852,763	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	847	0	1,842,260	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,774	2,872	0	192,291	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	445	0	0	1,303,131	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	520,291	85,460	0	86,168,313	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	108,173	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	19,530	0	0	0	194.00
194.01	07951	FOUNDATION	206	0	0	168,683	0	194.01
194.02	07952	RETAIL SERVICES	2,340	0	0	134,943	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	168,229	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	312	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	70,753	17,168	0	0	0	194.06
194.07	07957	HOME OFFICE	279,676	44,814	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
			1.00	1.01	2.00	4.00	5.01	
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)	21,376,768	6,215,457	0	17,258,745	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.479103	22.564164	0.000000	0.199200	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				9,436	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000109	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
			5.02	5.03	5.04	5.05	5A.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,512					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2	8,749,378				5.03
5.04	00570	ADMITTING	99	16,222	927,344,822			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	927,344,822		5.05
5.06	00590	OTHER A&G	61	24,834	0	0	-31,006,533	5.06
7.00	00700	OPERATION OF PLANT	5	14,369	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2	1,101	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3	5,594	0	0	0	9.00
10.00	01000	DIETARY	43	94,933	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11	1,057,761	0	0	0	14.00
15.00	01500	PHARMACY	55	979,521	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	27	30,599	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	66	38	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	27	1,973	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	13	1,510	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	277	842,343	53,037,756	53,037,756	0	30.00
31.00	03100	INTENSIVE CARE UNIT	43	292,011	9,147,300	9,147,300	0	31.00
40.00	04000	SUBPROVIDER - IPF	16	86,898	9,766,278	9,766,278	0	40.00
41.00	04100	SUBPROVIDER - IRF	35	63,607	4,572,574	4,572,574	0	41.00
43.00	04300	NURSERY	0	56,053	1,803,575	1,803,575	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113	1,593,964	163,377,021	163,377,021	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28	121,468	9,383,299	9,383,299	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121	1,357,309	136,194,232	136,194,232	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	23	671,460	103,504,290	103,504,290	0	59.00
60.00	06000	LABORATORY	95	153,093	97,452,158	97,452,158	0	60.00
65.00	06500	RESPIRATORY THERAPY	13	323,830	25,759,808	25,759,808	0	65.00
66.00	06600	PHYSICAL THERAPY	116	55,885	20,595,215	20,595,215	0	66.00
69.00	06900	ELECTROCARDIOLOGY	34	69,202	32,185,984	32,185,984	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17	17,616	4,337,806	4,337,806	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	30,381,862	30,381,862	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	124,359,377	124,359,377	0	73.00
74.00	07400	RENAL DIALYSIS	3	18,814	1,184,700	1,184,700	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7	9,580	1,288,607	1,288,607	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	111	385,610	86,818,259	86,818,259	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	10	69,022	6,317,339	6,317,339	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	8	151,483	454,844	454,844	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	23	143,208	5,422,538	5,422,538	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,507	8,710,911	927,344,822	927,344,822	-31,006,533	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,902	0	0	0	192.00
194.00	07950	RENTAL SPACE	5	22,301	0	0	0	194.00
194.01	07951	FOUNDATION	0	11,081	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	2,183	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
			5.02	5.03	5.04	5.05	5A.06	
202.00		Cost to be allocated (per Wkst. B, Part I)	13,865,026	302,072	6,049,659	270,032		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9,169.990741	0.034525	0.006524	0.000291		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	343,022	221,648	86,264	181,914		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	226.866402	0.025333	0.000093	0.000196		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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	260,549,475					5.06
7.00	00700	OPERATION OF PLANT	722,412	954,480				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,101,332	12,335	1,906,914			8.00
9.00	00900	HOUSEKEEPING	3,338,888	7,872	0	11,193		9.00
10.00	01000	DIETARY	2,276,491	18,463	0	694	56,069	10.00
11.00	01100	CAFETERIA	1,985,435	9,461	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	312,543	1,955	0	16	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,970,653	8,411	0	140	0	14.00
15.00	01500	PHARMACY	38,369,077	9,640	0	215	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	106,525	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,648,753	438	0	86	0	17.00
17.01	01701	INSERVICE EDUCATION	3,121,899	9,322	0	116	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,128,362	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	727,183	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	430,298	2,807	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,169,129	115,758	572,758	3,720	37,783	30.00
31.00	03100	INTENSIVE CARE UNIT	7,567,516	24,552	116,854	687	5,176	31.00
40.00	04000	SUBPROVIDER - IPF	5,156,746	22,340	132,324	709	8,936	40.00
41.00	04100	SUBPROVIDER - IRF	3,000,706	17,898	54,834	332	4,174	41.00
43.00	04300	NURSERY	625,895	2,681	0	28	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,016,434	40,624	290,198	1,031	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,655,764	8,316	102,549	230	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,729,030	53,880	186,846	638	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,418,251	4,593	103,439	150	0	59.00
60.00	06000	LABORATORY	14,470,957	20,194	0	539	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,665,835	1,194	0	100	0	65.00
66.00	06600	PHYSICAL THERAPY	11,482,744	48,220	18,204	88	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,770,364	557	0	150	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	679,976	5,400	7,723	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	17,261,477	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	847,510	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	855,838	1,490	0	156	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	734,773	3,662	0	40	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,924,804	30,962	264,552	897	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	2,638,978	0	56,633	240	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	420,083	3,752	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,052,764	0	0	171	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	238,385,425	486,777	1,906,914	11,173	56,069	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,477,380	108,173	0	0	0	192.00
194.00	07950	RENTAL SPACE	4,818,944	22,920	0	0	0	194.00
194.01	07951	FOUNDATION	633,947	206	0	10	0	194.01
194.02	07952	RETAIL SERVICES	248,424	684	0	10	0	194.02
194.03	07953	REID CONTRACTED SERVICES	341,815	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	7,040	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	624,536	0	0	0	0	194.05
194.06	07956	VACANT SPACE	2,154,558	93,036	0	0	0	194.06
194.07	07957	HOME OFFICE	7,857,406	242,684	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.06	7.00	8.00	9.00	10.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	31,006,533	808,382	1,242,842	3,742,896	2,795,111	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.119004	0.846934	0.651756	334.396140	49.851273	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	141,641	327,714	365,431	241,436	554,598	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000544	0.343343	0.191635	21.570267	9.891348	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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
			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
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,427,688					11.00
13.00	01300	NURSING ADMINISTRATION	2,080	1,543,730				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38,766	0	18,203,567			14.00
15.00	01500	PHARMACY	122,118	0	5,870	31,838,177		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	927,344,822	16.00
17.00	01700	SOCIAL SERVICE	71,507	0	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	45,214	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	36,118	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	6,441	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	5,335	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	693,976	693,976	49,949	5,918	53,037,756	30.00
31.00	03100	INTENSIVE CARE UNIT	99,955	99,955	45,577	346	9,147,300	31.00
40.00	04000	SUBPROVIDER - IPF	119,879	119,879	1,674	592	9,766,278	40.00
41.00	04100	SUBPROVIDER - IRF	48,678	48,678	6,569	38	4,572,574	41.00
43.00	04300	NURSERY	9,471	9,471	2,776	0	1,803,575	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,556	48,556	8,792,821	90,319	163,377,021	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,541	17,541	39,894	701	9,383,299	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	202,592	202,592	83,144	671,692	136,194,232	54.00
59.00	05900	CARDIAC CATHETERIZATION	56,274	56,274	7,425,114	291	103,504,290	59.00
60.00	06000	LABORATORY	166,120	0	1,438,314	60	97,452,158	60.00
65.00	06500	RESPIRATORY THERAPY	48,386	48,386	12,703	10	25,759,808	65.00
66.00	06600	PHYSICAL THERAPY	192,899	0	789	475	20,595,215	66.00
69.00	06900	ELECTROCARDIOLOGY	33,883	0	52,700	225,446	32,185,984	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,860	0	0	0	4,337,806	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	30,381,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,826	1,826	0	30,709,954	124,359,377	73.00
74.00	07400	RENAL DIALYSIS	0	0	113	24	1,184,700	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	13,578	13,578	129	0	1,288,607	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	183,018	183,018	25,056	23,840	86,818,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	69,586	0	0	24	6,317,339	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	10,591	0	218,355	0	454,844	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	46,191	0	2,020	108,447	5,422,538	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,402,439	1,543,730	18,203,567	31,838,177	927,344,822	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	6,955	0	0	0	0	194.01
194.02	07952	RETAIL SERVICES	7,331	0	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	10,963	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,229,723	358,653	5,651,725	43,129,294	119,202	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.918455	0.232329	0.310473	1.354641	0.000129	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	236,192	49,269	503,706	643,554	106,583	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.097291	0.031916	0.027671	0.020213	0.000115	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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	PARAMED ED PRGM (TIME SPENT)	
			17.00	17.01	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	55,486					17.00
17.01	01701	INSERVICE EDUCATION	0	15,852				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,546			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		1,546		22.00
23.00	02300	PARAMED ED PRGM	0	38			100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,649	5,062	1,201	1,201	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,085	709	125	125	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	851	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	348	0	0	0	41.00
43.00	04300	NURSERY	0	67	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,110	79	79	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	662	142	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,479	17	17	100	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	400	0	0	0	59.00
60.00	06000	LABORATORY	0	1,194	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	344	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,388	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	265	41	41	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	83	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	95	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,090	1,378	83	83	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	492	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	75	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	231			0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,486	15,751	1,546	1,546	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	49	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	52	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	PARAMED ED PRGM (TIME SPENT)	
		17.00	17.01	21.00	22.00	23.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,177,774	3,581,629	2,414,819	819,637	497,368	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	75.294200	225.941774	1,561.978655	530.166235	4,973.680000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	72,511	281,732	4,858	35,721	93,263	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.306834	17.772647	3.142303	23.105433	932.630000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 3:16 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	47,986,553		47,986,553	0	47,986,553	30.00
31.00	03100	INTENSIVE CARE UNIT	9,576,096		9,576,096	0	9,576,096	31.00
40.00	04000	SUBPROVIDER - IPF	6,890,953		6,890,953	0	6,890,953	40.00
41.00	04100	SUBPROVIDER - IRF	3,865,123		3,865,123	0	3,865,123	41.00
43.00	04300	NURSERY	739,145		739,145	0	739,145	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,979,420		33,979,420	0	33,979,420	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,120,259		2,120,259	0	2,120,259	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,356,576		23,356,576	0	23,356,576	54.00
59.00	05900	CARDIAC CATHETERIZATION	10,896,698		10,896,698	0	10,896,698	59.00
60.00	06000	LABORATORY	17,271,960		17,271,960	0	17,271,960	60.00
65.00	06500	RESPIRATORY THERAPY	3,158,217	0	3,158,217	0	3,158,217	65.00
66.00	06600	PHYSICAL THERAPY	13,425,688	0	13,425,688	0	13,425,688	66.00
69.00	06900	ELECTROCARDIOLOGY	3,567,586		3,567,586	0	3,567,586	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	800,709		800,709	0	800,709	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,319,581		19,319,581	0	19,319,581	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,567,465		42,567,465	0	42,567,465	73.00
74.00	07400	RENAL DIALYSIS	1,011,335		1,011,335	0	1,011,335	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	875,987		875,987	0	875,987	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,131,747		14,131,747	0	14,131,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,330,949		5,330,949		5,330,949	92.00
93.00	04040	FAMILY PRACTICE	3,246,116		3,246,116	0	3,246,116	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	567,778		567,778	0	567,778	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,716,088		3,716,088		3,716,088	116.00
200.00		Subtotal (see instructions)	268,402,029	0	268,402,029	0	268,402,029	200.00
201.00		Less Observation Beds	5,330,949		5,330,949		5,330,949	201.00
202.00		Total (see instructions)	263,071,080	0	263,071,080	0	263,071,080	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 3:16 pm

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		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	42,996,121		42,996,121			30.00
31.00	03100	INTENSIVE CARE UNIT	9,147,300		9,147,300			31.00
40.00	04000	SUBPROVIDER - IPF	9,766,278		9,766,278			40.00
41.00	04100	SUBPROVIDER - IRF	4,572,574		4,572,574			41.00
43.00	04300	NURSERY	1,803,575		1,803,575			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,749,355	106,627,666	163,377,021	0.207982	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,408,216	975,083	9,383,299	0.225961	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,922,291	101,271,941	136,194,232	0.171495	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	39,683,089	63,821,201	103,504,290	0.105278	0.000000	59.00
60.00	06000	LABORATORY	37,298,975	60,153,183	97,452,158	0.177235	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	22,744,196	3,015,612	25,759,808	0.122603	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,456,544	12,138,671	20,595,215	0.651884	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,242,101	19,943,883	32,185,984	0.110843	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,214	4,327,592	4,337,806	0.184588	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,273,451	11,108,411	30,381,862	0.635892	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,529,771	74,829,606	124,359,377	0.342294	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,114,929	69,771	1,184,700	0.853663	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	2,321	1,286,286	1,288,607	0.679794	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	23,162,244	63,656,015	86,818,259	0.162774	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,277,306	6,764,329	10,041,635	0.530885	0.000000	92.00
93.00	04040	FAMILY PRACTICE	17,583	6,299,756	6,317,339	0.513842	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	454,844	454,844	1.248292	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,252,876	4,169,662	5,422,538			116.00
200.00		Subtotal (see instructions)	386,431,310	540,913,512	927,344,822			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	386,431,310	540,913,512	927,344,822			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.207982	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	59.00
60.00	06000	LABORATORY	0.177235	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	73.00
74.00	07400	RENAL DIALYSIS	0.853663	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.162774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	92.00
93.00	04040	FAMILY PRACTICE	0.513842	93.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	96.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 3:16 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	47,986,553		47,986,553	0	47,986,553	30.00
31.00	03100	INTENSIVE CARE UNIT	9,576,096		9,576,096	0	9,576,096	31.00
40.00	04000	SUBPROVIDER - IPF	6,890,953		6,890,953	0	6,890,953	40.00
41.00	04100	SUBPROVIDER - IRF	3,865,123		3,865,123	0	3,865,123	41.00
43.00	04300	NURSERY	739,145		739,145	0	739,145	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,979,420		33,979,420	0	33,979,420	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,120,259		2,120,259	0	2,120,259	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,356,576		23,356,576	0	23,356,576	54.00
59.00	05900	CARDIAC CATHETERIZATION	10,896,698		10,896,698	0	10,896,698	59.00
60.00	06000	LABORATORY	17,271,960		17,271,960	0	17,271,960	60.00
65.00	06500	RESPIRATORY THERAPY	3,158,217	0	3,158,217	0	3,158,217	65.00
66.00	06600	PHYSICAL THERAPY	13,425,688	0	13,425,688	0	13,425,688	66.00
69.00	06900	ELECTROCARDIOLOGY	3,567,586		3,567,586	0	3,567,586	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	800,709		800,709	0	800,709	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,319,581		19,319,581	0	19,319,581	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,567,465		42,567,465	0	42,567,465	73.00
74.00	07400	RENAL DIALYSIS	1,011,335		1,011,335	0	1,011,335	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	875,987		875,987	0	875,987	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,131,747		14,131,747	0	14,131,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,330,949		5,330,949		5,330,949	92.00
93.00	04040	FAMILY PRACTICE	3,246,116		3,246,116	0	3,246,116	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	567,778		567,778	0	567,778	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,716,088		3,716,088		3,716,088	116.00
200.00		Subtotal (see instructions)	268,402,029	0	268,402,029	0	268,402,029	200.00
201.00		Less Observation Beds	5,330,949		5,330,949		5,330,949	201.00
202.00		Total (see instructions)	263,071,080	0	263,071,080	0	263,071,080	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 3:16 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	42,996,121		42,996,121			30.00
31.00	03100	INTENSIVE CARE UNIT	9,147,300		9,147,300			31.00
40.00	04000	SUBPROVIDER - IPF	9,766,278		9,766,278			40.00
41.00	04100	SUBPROVIDER - IRF	4,572,574		4,572,574			41.00
43.00	04300	NURSERY	1,803,575		1,803,575			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,749,355	106,627,666	163,377,021	0.207982	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,408,216	975,083	9,383,299	0.225961	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,922,291	101,271,941	136,194,232	0.171495	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	39,683,089	63,821,201	103,504,290	0.105278	0.000000	59.00
60.00	06000	LABORATORY	37,298,975	60,153,183	97,452,158	0.177235	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	22,744,196	3,015,612	25,759,808	0.122603	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,456,544	12,138,671	20,595,215	0.651884	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,242,101	19,943,883	32,185,984	0.110843	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,214	4,327,592	4,337,806	0.184588	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,273,451	11,108,411	30,381,862	0.635892	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,529,771	74,829,606	124,359,377	0.342294	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,114,929	69,771	1,184,700	0.853663	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	2,321	1,286,286	1,288,607	0.679794	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	23,162,244	63,656,015	86,818,259	0.162774	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,277,306	6,764,329	10,041,635	0.530885	0.000000	92.00
93.00	04040	FAMILY PRACTICE	17,583	6,299,756	6,317,339	0.513842	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	454,844	454,844	1.248292	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,252,876	4,169,662	5,422,538			116.00
200.00		Subtotal (see instructions)	386,431,310	540,913,512	927,344,822			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	386,431,310	540,913,512	927,344,822			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 3:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
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
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	ANCILLARY - OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	FAMILY PRACTICE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 6/8/2020 3:16 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	4,398,269	0	4,398,269	42,505	103.48	30.00
31.00	INTENSIVE CARE UNIT	1,245,040		1,245,040	5,176	240.54	31.00
40.00	SUBPROVIDER - IPF	755,081	0	755,081	8,936	84.50	40.00
41.00	SUBPROVIDER - IRF	574,325	0	574,325	4,174	137.60	41.00
43.00	NURSERY	78,789		78,789	1,889	41.71	43.00
200.00	Total (lines 30 through 199)	7,051,504		7,051,504	62,680		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	18,784	1,943,768	30.00
31.00	INTENSIVE CARE UNIT	2,708	651,382	31.00
40.00	SUBPROVIDER - IPF	5,589	472,271	40.00
41.00	SUBPROVIDER - IRF	2,744	377,574	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	29,825	3,444,995	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/8/2020 3:16 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	2,917,361	163,377,021	0.017857	35,534,512	634,540	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,678	9,383,299	0.030872	17,844	551	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,054,397	136,194,232	0.022427	19,805,816	444,185	54.00
59.00	05900	CARDIAC CATHETERIZATION	884,525	103,504,290	0.008546	22,861,784	195,377	59.00
60.00	06000	LABORATORY	1,366,137	97,452,158	0.014019	19,943,956	279,594	60.00
65.00	06500	RESPIRATORY THERAPY	135,126	25,759,808	0.005246	11,184,430	58,674	65.00
66.00	06600	PHYSICAL THERAPY	1,368,529	20,595,215	0.066449	2,655,168	176,433	66.00
69.00	06900	ELECTROCARDIOLOGY	312,365	32,185,984	0.009705	3,954,304	38,377	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,063	4,337,806	0.027448	5,624	154	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,665	30,381,862	0.000713	11,558,495	8,241	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,686	124,359,377	0.005401	24,830,973	134,112	73.00
74.00	07400	RENAL DIALYSIS	52,397	1,184,700	0.044228	703,386	31,109	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	216,148	1,288,607	0.167738	333	56	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,251,128	86,818,259	0.014411	12,904,310	185,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	488,613	10,041,635	0.048659	1,740,235	84,678	92.00
93.00	04040	FAMILY PRACTICE	82,716	6,317,339	0.013093	17,299	226	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	125,599	454,844	0.276136	0	0	96.00
200.00		Total (lines 50 through 199)	13,357,133	853,636,436		167,718,469	2,272,271	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	42,505	0.00	18,784	30.00
31.00	03100	INTENSIVE CARE UNIT		0	5,176	0.00	2,708	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	8,936	0.00	5,589	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,174	0.00	2,744	41.00
43.00	04300	NURSERY		0	1,889	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	62,680		29,825	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/8/2020 3:16 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	497,368	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	497,368	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/8/2020 3:16 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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	163,377,021	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,383,299	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	497,368	497,368	136,194,232	0.003652	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	103,504,290	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	97,452,158	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	25,759,808	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,595,215	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,185,984	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,337,806	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	30,381,862	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	124,359,377	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,184,700	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,288,607	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	86,818,259	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,041,635	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	6,317,339	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	454,844	0.000000	96.00
200.00		Total (lines 50 through 199)	0	497,368	497,368	853,636,436		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/8/2020 3:16 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	35,534,512	0	39,421,662	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	17,844	0	2,714	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003652	19,805,816	72,331	44,614,215	162,931	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	22,861,784	0	33,422,168	0	59.00
60.00	06000	LABORATORY	0.000000	19,943,956	0	9,976,179	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	11,184,430	0	1,381,813	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,655,168	0	40,690	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,954,304	0	10,878,784	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	5,624	0	1,941,351	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	11,558,495	0	5,055,898	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	24,830,973	0	35,058,959	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	703,386	0	35,951	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	333	0	508,501	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	12,904,310	0	16,379,840	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,740,235	0	1,564,318	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	17,299	0	1,650,058	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		167,718,469	72,331	201,933,101	162,931	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/8/2020 3:16 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	0.207982	39,421,662	0	0	8,198,996	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	2,714	0	0	613	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	44,614,215	0	0	7,651,115	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	33,422,168	0	0	3,518,619	59.00
60.00	06000	LABORATORY	0.177235	9,976,179	0	0	1,768,128	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	1,381,813	0	0	169,414	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	40,690	0	0	26,525	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	10,878,784	0	0	1,205,837	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	1,941,351	0	0	358,350	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	5,055,898	0	0	3,215,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	35,058,959	0	51,608	12,000,471	73.00
74.00	07400	RENAL DIALYSIS	0.853663	35,951	0	0	30,690	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	508,501	0	0	345,676	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.162774	16,379,840	0	0	2,666,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	1,564,318	0	0	830,473	92.00
93.00	04040	FAMILY PRACTICE	0.513842	1,650,058	0	0	847,869	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	0	0	96.00
200.00		Subtotal (see instructions)		201,933,101	0	51,608	42,833,993	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		201,933,101	0	51,608	42,833,993	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/8/2020 3:16 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
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
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	17,665		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY - OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	17,665		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	17,665		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,917,361	163,377,021	0.017857	75,639	1,351	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,678	9,383,299	0.030872	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,054,397	136,194,232	0.022427	434,357	9,741	54.00
59.00	05900	CARDIAC CATHETERIZATION	884,525	103,504,290	0.008546	27,092	232	59.00
60.00	06000	LABORATORY	1,366,137	97,452,158	0.014019	758,851	10,638	60.00
65.00	06500	RESPIRATORY THERAPY	135,126	25,759,808	0.005246	623,847	3,273	65.00
66.00	06600	PHYSICAL THERAPY	1,368,529	20,595,215	0.066449	285,464	18,969	66.00
69.00	06900	ELECTROCARDIOLOGY	312,365	32,185,984	0.009705	19,712	191	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,063	4,337,806	0.027448	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,665	30,381,862	0.000713	8	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,686	124,359,377	0.005401	1,313,459	7,094	73.00
74.00	07400	RENAL DIALYSIS	52,397	1,184,700	0.044228	37,700	1,667	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	216,148	1,288,607	0.167738	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,251,128	86,818,259	0.014411	579,969	8,358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	10,041,635	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	82,716	6,317,339	0.013093	284	4	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	125,599	454,844	0.276136	0	0	96.00
200.00		Total (lines 50 through 199)	12,868,520	853,636,436		4,156,382	61,518	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	497,368	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	497,368	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	163,377,021	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,383,299	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	497,368	497,368	136,194,232	0.003652	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	103,504,290	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	97,452,158	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	25,759,808	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,595,215	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,185,984	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,337,806	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	30,381,862	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	124,359,377	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,184,700	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,288,607	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	86,818,259	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,041,635	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	6,317,339	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	454,844	0.000000	96.00
200.00		Total (lines 50 through 199)	0	497,368	497,368	853,636,436		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	75,639	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003652	434,357	1,586	3,169	12	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	27,092	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	758,851	0	400	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	623,847	0	303	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	285,464	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	19,712	0	447	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	8	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,313,459	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	37,700	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	579,969	0	1,119	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	284	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		4,156,382	1,586	5,438	12	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | 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	0.207982	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	3,169	0	0	543	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	0	0	0	0	59.00
60.00	06000	LABORATORY	0.177235	400	0	0	71	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	303	0	0	37	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	447	0	0	50	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	0	0	3,058	0	73.00
74.00	07400	RENAL DIALYSIS	0.853663	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.162774	1,119	0	0	182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.513842	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	0	0	96.00
200.00		Subtotal (see instructions)		5,438	0	3,058	883	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		5,438	0	3,058	883	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
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
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	1,047		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY - OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	1,047		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,047		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,917,361	163,377,021	0.017857	52,920	945	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,678	9,383,299	0.030872	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,054,397	136,194,232	0.022427	149,340	3,349	54.00
59.00	05900	CARDIAC CATHETERIZATION	884,525	103,504,290	0.008546	13,123	112	59.00
60.00	06000	LABORATORY	1,366,137	97,452,158	0.014019	401,853	5,634	60.00
65.00	06500	RESPIRATORY THERAPY	135,126	25,759,808	0.005246	419,322	2,200	65.00
66.00	06600	PHYSICAL THERAPY	1,368,529	20,595,215	0.066449	2,329,727	154,808	66.00
69.00	06900	ELECTROCARDIOLOGY	312,365	32,185,984	0.009705	7,115	69	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,063	4,337,806	0.027448	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,665	30,381,862	0.000713	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,686	124,359,377	0.005401	839,924	4,536	73.00
74.00	07400	RENAL DIALYSIS	52,397	1,184,700	0.044228	44,200	1,955	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	216,148	1,288,607	0.167738	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,251,128	86,818,259	0.014411	20,870	301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	10,041,635	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	82,716	6,317,339	0.013093	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	125,599	454,844	0.276136	0	0	96.00
200.00		Total (lines 50 through 199)	12,868,520	853,636,436		4,278,394	173,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	497,368	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	497,368	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | 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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	163,377,021	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,383,299	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	497,368	497,368	136,194,232	0.003652	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	103,504,290	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	97,452,158	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	25,759,808	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,595,215	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,185,984	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,337,806	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	30,381,862	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	124,359,377	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,184,700	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,288,607	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	86,818,259	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,041,635	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	6,317,339	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	454,844	0.000000	96.00
200.00		Total (lines 50 through 199)	0	497,368	497,368	853,636,436		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | 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	52,920	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003652	149,340	545	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	13,123	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	401,853	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	419,322	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,329,727	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,115	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	839,924	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	44,200	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	20,870	0	240	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		4,278,394	545	240	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | 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	0.207982	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	0	0	0	0	59.00
60.00	06000	LABORATORY	0.177235	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	0	0	344	0	73.00
74.00	07400	RENAL DIALYSIS	0.853663	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.162774	240	0	0	39	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.513842	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	0	0	96.00
200.00		Subtotal (see instructions)		240	0	344	39	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		240	0	344	39	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
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
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	118		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY - OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	118		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	118		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/8/2020 3:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.207982	0	2,028,007	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	0	89,246	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	0	3,066,963	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	0	760,115	0	0	59.00
60.00	06000	LABORATORY	0.177235	0	1,996,499	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	0	88,820	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	0	863,618	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	0	277,984	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	0	67,379	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	0	235,267	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	0	1,719,130	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.853663	0	960	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	0	6,502	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.162774	0	3,575,022	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	0	527,106	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.513842	0	141,611	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	15,444,229	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	15,444,229	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/8/2020 3:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	421,789	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,166	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525,969	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	80,023	0	59.00
60.00	06000	LABORATORY	353,850	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,890	0	65.00
66.00	06600	PHYSICAL THERAPY	562,979	0	66.00
69.00	06900	ELECTROCARDIOLOGY	30,813	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,437	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	149,604	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	588,448	0	73.00
74.00	07400	RENAL DIALYSIS	820	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,420	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	581,921	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	279,833	0	92.00
93.00	04040	FAMILY PRACTICE	72,766	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	3,696,728	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	3,696,728	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 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)	42,505	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	42,505	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)	37,783	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)	18,784	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)	47,986,553	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)	47,986,553	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)	47,986,553	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)	1,128.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	21,206,385	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)	21,206,385	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 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	9,576,096	5,176	1,850.10	2,708	5,010,071	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)	39,757,600	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	65,974,056	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	2,595,150	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,344,602	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,939,752	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	61,034,304	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)	4,722	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,128.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,330,949	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 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	4,398,269	47,986,553	0.091656	5,330,949	488,613	90.00
91.00	Nursing School cost	0	47,986,553	0.000000	5,330,949	0	91.00
92.00	Allied health cost	0	47,986,553	0.000000	5,330,949	0	92.00
93.00	All other Medical Education	0	47,986,553	0.000000	5,330,949	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,936	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,936	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)	8,936	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)	5,589	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,890,953	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,890,953	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,890,953	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)	771.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,309,957	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,309,957	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,068,656	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,378,613	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)	472,271	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	63,104	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	535,375	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,843,238	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	755,081	6,890,953	0.109576	0	0	90.00
91.00	Nursing School cost	0	6,890,953	0.000000	0	0	91.00
92.00	Allied health cost	0	6,890,953	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,890,953	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,174	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,174	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)	4,174	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)	2,744	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,865,123	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,865,123	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,865,123	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)	926.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,540,944	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)	2,540,944	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,008,762	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,549,706	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)	377,574	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	174,454	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	552,028	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,997,678	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	574,325	3,865,123	0.148592	0	0	90.00
91.00	Nursing School cost	0	3,865,123	0.000000	0	0	91.00
92.00	Allied health cost	0	3,865,123	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,865,123	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 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)	42,505	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	42,505	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)	37,783	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,545	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,889	15.00
16.00	Nursery days (title V or XIX only)	77	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)	47,986,553	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)	47,986,553	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)	47,986,553	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)	1,128.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,744,243	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,744,243	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 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)	739,145	1,889	391.29	77	30,129	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,576,096	5,176	1,850.10	213	394,071	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)	1,919,662	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,088,105	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)	4,722	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,128.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,330,949	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 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	4,398,269	47,986,553	0.091656	5,330,949	488,613	90.00
91.00	Nursing School cost	0	47,986,553	0.000000	5,330,949	0	91.00
92.00	Allied health cost	0	47,986,553	0.000000	5,330,949	0	92.00
93.00	All other Medical Education	0	47,986,553	0.000000	5,330,949	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,936	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,936	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)	8,936	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)	102	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,889	15.00
16.00	Nursery days (title V or XIX only)	77	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,890,953	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,890,953	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,890,953	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)	771.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	78,657	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)	78,657	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	78,657	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	755,081	6,890,953	0.109576	0	0	90.00
91.00	Nursing School cost	0	6,890,953	0.000000	0	0	91.00
92.00	Allied health cost	0	6,890,953	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,890,953	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,174	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,174	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)	4,174	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,889	15.00
16.00	Nursery days (title V or XIX only)	77	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,865,123	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,865,123	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,865,123	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)	926.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	574,325	3,865,123	0.148592	0	0	90.00
91.00	Nursing School cost	0	3,865,123	0.000000	0	0	91.00
92.00	Allied health cost	0	3,865,123	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,865,123	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 3:16 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		26,059,167		30.00
31.00	03100	INTENSIVE CARE UNIT		4,935,683		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.207982	35,534,512	7,390,539	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	17,844	4,032	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	19,805,816	3,396,598	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	22,861,784	2,406,843	59.00
60.00	06000	LABORATORY	0.177235	19,943,956	3,534,767	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	11,184,430	1,371,245	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	2,655,168	1,730,862	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	3,954,304	438,307	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	5,624	1,038	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	11,558,495	7,349,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	24,830,973	8,499,493	73.00
74.00	07400	RENAL DIALYSIS	0.853663	703,386	600,455	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	333	226	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.162774	12,904,310	2,100,486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	1,740,235	923,865	92.00
93.00	04040	FAMILY PRACTICE	0.513842	17,299	8,889	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		167,718,469	39,757,600	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)		167,718,469		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		6,122,701		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.207982	75,639	15,732	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	434,357	74,490	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	27,092	2,852	59.00
60.00	06000	LABORATORY	0.177235	758,851	134,495	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	623,847	76,486	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	285,464	186,089	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	19,712	2,185	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	8	5	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	1,313,459	449,589	73.00
74.00	07400	RENAL DIALYSIS	0.853663	37,700	32,183	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.162774	579,969	94,404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.513842	284	146	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,156,382	1,068,656	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)		4,156,382		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		3,006,025		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.207982	52,920	11,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	149,340	25,611	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	13,123	1,382	59.00
60.00	06000	LABORATORY	0.177235	401,853	71,222	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	419,322	51,410	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	2,329,727	1,518,712	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	7,115	789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	839,924	287,501	73.00
74.00	07400	RENAL DIALYSIS	0.853663	44,200	37,732	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.162774	20,870	3,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.513842	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,278,394	2,008,762	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)		4,278,394		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 3:16 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		2,425,610		30.00
31.00	03100	INTENSIVE CARE UNIT		356,857		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		382,079		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.207982	668,887	139,116	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	670,859	151,588	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	1,116,545	191,482	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	502,225	52,873	59.00
60.00	06000	LABORATORY	0.177235	1,400,905	248,289	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	562,407	68,953	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	389,906	254,173	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	158,767	17,598	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	81,802	52,017	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	1,661,216	568,624	73.00
74.00	07400	RENAL DIALYSIS	0.853663	46,460	39,661	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.162774	831,142	135,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.513842	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,091,121	1,919,662	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)		8,091,121		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		521,596		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.207982	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	0	0	59.00
60.00	06000	LABORATORY	0.177235	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.853663	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.162774	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.513842	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		14,241		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.207982	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225961	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171495	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.105278	0	0	59.00
60.00	06000	LABORATORY	0.177235	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.122603	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.651884	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110843	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.184588	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.635892	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342294	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.853663	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.679794	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.162774	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.530885	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.513842	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.248292	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/8/2020 3:16 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)	38,124,366	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	13,002,902	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)	836,084	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	199,392	2.04
3.00	Managed Care Simulated Payments	7,414,266	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	150.06	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	15.47	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	15.47	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.103092	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.101230	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.101230	21.00
22.00	IME payment adjustment (see instructions)	2,748,858	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	398,628	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)	2,748,858	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	398,628	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.42	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.99	31.00
32.00	Sum of lines 30 and 31	25.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.18	33.00
34.00	Disproportionate share adjustment (see instructions)	1,301,189	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Prepared: 6/8/2020 3:16 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)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000381928	0.000381928	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,074,238	891,518	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	2,299,361	224,097	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,523,458		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)	58,736,249		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	68,634,364		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	69,032,992	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	4,398,955	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).	510,931	52.00
53.00	Nursing and Allied Health Managed Care payment	36,977	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)	72,331	58.00
59.00	Total (sum of amounts on lines 49 through 58)	74,052,186	59.00
60.00	Primary payer payments	15,195	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	74,036,991	61.00
62.00	Deductibles billed to program beneficiaries	5,667,872	62.00
63.00	Coinsurance billed to program beneficiaries	57,629	63.00
64.00	Allowable bad debts (see instructions)	400,921	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	260,599	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	196,409	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	68,572,089	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)	69,211	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/8/2020 3:16 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)		68,641,300	71.00
71.01	Sequestration adjustment (see instructions)		1,372,826	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		67,707,570	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-439,096	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	17,665	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	42,671,062	2.00
3.00	OPPS payments	52,382,907	3.00
4.00	Outlier payment (see instructions)	31,461	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	162,931	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	17,665	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	51,608	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)	51,608	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)	51,608	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	33,943	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)	17,665	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)	52,577,299	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)	9,252,963	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)	43,342,001	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	288,467	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)	43,630,468	30.00
31.00	Primary payer payments	8,595	31.00
32.00	Subtotal (line 30 minus line 31)	43,621,873	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)	1,553,271	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,009,626	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,340,915	36.00
37.00	Subtotal (see instructions)	44,631,499	37.00
38.00	MSP-LCC reconciliation amount from PS&R	2,042	38.00
39.00	OTHER ADJUSTMENTS	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)	44,629,457	40.00
40.01	Sequestration adjustment (see instructions)	892,589	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	43,751,853	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-14,985	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,047	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	871	2.00
3.00	OPPS payments	1,146	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	12	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,047	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,058	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)	3,058	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)	3,058	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,011	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,047	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)	1,158	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)	135	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,070	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,070	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,070	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,070	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,070	40.00
40.01	Sequestration adjustment (see instructions)	41	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,501	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	528	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	118	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	39	2.00
3.00	OPPS payments	101	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	118	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	344	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)	344	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)	344	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	226	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)	118	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)	101	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)	0	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)	219	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)	219	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	219	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	219	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	219	40.00
40.01	Sequestration adjustment (see instructions)	4	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	209	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	6	43.00
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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/8/2020 3:16 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		67,634,570		43,465,853	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	04/24/2019	73,000	04/24/2019	110,100	3.01
3.02			0	07/27/2019	175,900	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)		73,000		286,000	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)		67,707,570		43,751,853	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		439,096		14,985	6.02
7.00	Total Medicare program liability (see instructions)		67,268,474		43,736,868	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,875,383		1,501	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,875,383		1,501	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		64,418		528	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,939,801		2,029	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,548,573		209	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,548,573		209	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		6	6.01
6.02	SETTLEMENT TO PROGRAM		26,504		0	6.02
7.00	Total Medicare program liability (see instructions)		4,522,069		215	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: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/8/2020 3:16 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: 15-0048 Component CCN: 15-S048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	5,587,738	1.00
2.00	Net IPF PPS Outlier Payments	28,023	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	24.482192	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	5,615,761	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	5,615,761	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	5,615,761	18.00
19.00	Deductibles	290,292	19.00
20.00	Subtotal (line 18 minus line 19)	5,325,469	20.00
21.00	Coinsurance	350,583	21.00
22.00	Subtotal (line 20 minus line 21)	4,974,886	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	98,679	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	64,141	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,156	25.00
26.00	Subtotal (sum of lines 22 and 24)	5,039,027	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	1,586	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	5,040,613	31.00
31.01	Sequestration adjustment (see instructions)	100,812	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	4,875,383	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	64,418	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	28,023	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part III Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,374,161	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0175	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	118,540	3.00
4.00	Outlier Payments	160,954	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	11.435616	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,653,655	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,653,655	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,653,655	19.00
20.00	Deductibles	15,004	20.00
21.00	Subtotal (line 19 minus line 20)	4,638,651	21.00
22.00	Coinsurance	26,598	22.00
23.00	Subtotal (line 21 minus line 22)	4,612,053	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,704	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,758	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,364	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,613,811	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	545	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,614,356	32.00
32.01	Sequestration adjustment (see instructions)	92,287	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,548,573	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-26,504	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	160,954	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/8/2020 3:16 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	4,088,105		1.00
2.00	Medical and other services		3,696,728	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,088,105	3,696,728	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)	4,088,105	3,696,728	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	8,091,121	15,444,229	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)	8,091,121	15,444,229	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)	8,091,121	15,444,229	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,003,016	11,747,501	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)	4,088,105	3,696,728	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)	4,088,105	3,696,728	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)	4,088,105	3,696,728	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)	4,088,105	3,696,728	36.00
37.00	TO ZERO OUT MEDICAID	-4,088,105	-3,696,728	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/8/2020 3:16 pm
	Title XIX	Subprovider - IPF	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	78,657		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)	78,657	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)	78,657	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	78,657	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)	0	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)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	78,657	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/8/2020 3:16 pm
	Title XIX	Subprovider - IRF	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	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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)	0	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)	0	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)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-4 | Date/Time Prepared: 6/8/2020 3:16 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			15.47	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	15.47	0.00	15.47	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	15.47	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	15.47	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	15.47	0.00		17.00
18.00	Per resident amount	85,000.00	85,000.00		18.00
19.00	Approved amount for resident costs	1,314,950	0	1,314,950	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			15.47	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			85,000.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,314,950	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	29,825	5,101		26.00
27.00	Total Inpatient Days (see instructions)	56,265	56,265		27.00
28.00	Ratio of inpatient days to total inpatient days	0.530081	0.090660		28.00
29.00	Program direct GME amount	697,030	119,213		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		16,845		30.00
31.00	Net Program direct GME amount			799,398	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	1,184,700	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	75,902,375	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	15,195	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	75,887,180	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	42,853,745	42.00
43.00	Primary payer payments (see instructions)	8,595	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	42,845,150	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	118,732,330	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.639145	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.360855	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	799,398	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	510,931	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	288,467	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/8/2020 3:16 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	44,535,838	0	0	0	1.00
2.00	Temporary investments	316,214,676	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	139,079,903	0	0	0	4.00
5.00	Other receivable	451,725,089	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-71,780,924	0	0	0	6.00
7.00	Inventory	7,651,836	0	0	0	7.00
8.00	Prepaid expenses	5,390,731	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	100	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	892,817,249	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	16,281,439	0	0	0	12.00
13.00	Land improvements	13,517,691	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	311,331,989	0	0	0	15.00
16.00	Accumulated depreciation	-155,901,003	0	0	0	16.00
17.00	Leasehold improvements	12,979,130	0	0	0	17.00
18.00	Accumulated depreciation	-5,923,221	0	0	0	18.00
19.00	Fixed equipment	2,180,808	0	0	0	19.00
20.00	Accumulated depreciation	-1,628,181	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	172,254,105	0	0	0	23.00
24.00	Accumulated depreciation	-139,291,865	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)	225,800,892	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	73,383,344	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	73,383,344	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,192,001,485	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	21,723,763	0	0	0	37.00
38.00	Salaries, wages, and fees payable	15,303,102	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	9,843,148	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	3,283,592				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	50,153,605	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	235,798,109	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,000,229	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	238,798,338	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	288,951,943	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	903,049,542				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)	903,049,542	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,192,001,485	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/8/2020 3:16 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		787,785,815		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		206,394,683				2.00
3.00	Total (sum of line 1 and line 2)		994,180,498		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)		994,180,498		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	AMOUNTS INCLUDED IN HO COST REPORT	91,130,956		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)		91,130,956		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		903,049,542		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	AMOUNTS INCLUDED IN HO COST REPORT		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: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/8/2020 3:16 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	61,030,621		61,030,621	1.00
2.00	SUBPROVIDER - IPF	9,860,648		9,860,648	2.00
3.00	SUBPROVIDER - IRF	4,688,780		4,688,780	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)	75,580,049		75,580,049	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,777,295		11,777,295	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)	11,777,295		11,777,295	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	87,357,344		87,357,344	17.00
18.00	Ancillary services	285,895,350	484,700,792	770,596,142	18.00
19.00	Outpatient services	22,648,258	71,235,447	93,883,705	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				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	0	5,420,528	5,420,528	26.00
27.00	OTHER	3,132,321	1,748,061	4,880,382	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	399,033,273	563,104,828	962,138,101	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		281,251,567		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)		281,251,567		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 6/8/2020 3:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	962,138,101	1.00
2.00	Less contractual allowances and discounts on patients' accounts	541,733,194	2.00
3.00	Net patient revenues (line 1 minus line 2)	420,404,907	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	281,251,567	4.00
5.00	Net income from service to patients (line 3 minus line 4)	139,153,340	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	55,170,508	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	396,923	13.00
14.00	Revenue from meals sold to employees and guests	3,940,191	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	20,000	17.00
18.00	Revenue from sale of medical records and abstracts	300	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	68,434	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	13,739	21.00
22.00	Rental of hospital space	6,294,493	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,336,755	24.00
25.00	Total other income (sum of lines 6-24)	67,241,343	25.00
26.00	Total (line 5 plus line 25)	206,394,683	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)	206,394,683	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		900	900	-900	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		2,126	2,126	0	2,126	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	72,284	72,284	24,836	97,120	3.00
4.00	ADMINISTRATIVE & GENERAL*	608,933	36,241	645,174	14,629	659,803	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	2,782	2,782	0	2,782	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	101,294	101,294	0	101,294	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	108,447	108,447	0	108,447	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	186,702	186,702	0	186,702	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	206,011	0	206,011	192,903	398,914	28.00
29.00	LPN/LVN**	63,551	0	63,551	76,549	140,100	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	84,419	0	84,419	56,136	140,555	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	141,094	141,094	24,486	165,580	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	526,772	526,772	0	526,772	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	962,914	1,178,642	2,141,556	388,639	2,530,195	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	2,126		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	-717	96,403		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	659,803		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	2,782		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	101,294		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	108,447		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	186,702		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	398,914		28.00
29.00	LPN/LVN**	0	140,100		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	140,555		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	165,580		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	526,772		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-717	2,529,478		100.00

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

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

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-2 | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	186,702	186,702	0	186,702	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	206,011	0	206,011	0	206,011	28.00
29.00	LPN/LVN	63,551	0	63,551	0	63,551	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	84,419	0	84,419	0	84,419	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	141,094	141,094	0	141,094	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	526,772	526,772	0	526,772	46.00
100.00	TOTAL *	353,981	854,568	1,208,549	0	1,208,549	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	186,702		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	206,011		28.00
29.00	LPN/LVN	0	63,551		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	84,419		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	141,094		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	526,772		46.00
100.00	TOTAL *	0	1,208,549		100.00

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

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

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-3 | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	23,997	23,997	28.00
29.00	LPN/LVN	0	0	0	9,523	9,523	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	6,983	6,983	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	3,046	3,046	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	43,549	43,549	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	23,997		28.00
29.00	LPN/LVN	0	9,523		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	6,983		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	3,046		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	43,549		100.00

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

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

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-4 | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	168,906	168,906	28.00
29.00	LPN/LVN	0	0	0	67,026	67,026	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	49,153	49,153	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	21,440	21,440	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	306,525	306,525	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	168,906		28.00
29.00	LPN/LVN	0	67,026		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	49,153		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	21,440		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	306,525		100.00

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

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

Provider CCN: 15-0048 Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-5 | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	10,893	10,893	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,126	0	2,126	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	96,403	259,584	355,987	3.00
4.00	ADMINISTRATIVE & GENERAL	659,803	658,524	1,318,327	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	57,182	57,182	7.00
8.00	DIETARY	2,782	0	2,782	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	627	627	10.00
11.00	MEDICAL RECORDS	0	700	700	11.00
12.00	STAFF TRANSPORTATION	101,294		101,294	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	108,447	146,907	255,354	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		52,193	52,193	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,208,549		1,208,549	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	43,549		43,549	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	306,525		306,525	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,529,478	1,186,610	3,716,088	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6 Part I
Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,893	10,893				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,126		2,126			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	355,987	0	0	355,987		3.00
4.00	ADMINISTRATIVE & GENERAL	1,318,327	10,893	0	170,343	1,499,563	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	57,182	0	0	0	57,182	7.00
8.00	DIETARY	2,782	0	0	0	2,782	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	627	0	0	0	627	10.00
11.00	MEDICAL RECORDS	700	0	0	0	700	11.00
12.00	STAFF TRANSPORTATION	101,294	0	0	0	101,294	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	255,354	0	0	0	255,354	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		52,193	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,208,549			96,700	1,305,249	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	43,549	0	263	11,065	54,877	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	306,525	0	1,863	77,879	386,267	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,716,088	10,893	2,126	355,987	3,716,088	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6 Part I
Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	1,499,563					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	38,686	0		95,868		7.00
8.00	DIETARY	1,882	0		0	4,664	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	424	0		0		10.00
11.00	MEDICAL RECORDS	474	0		0		11.00
12.00	STAFF TRANSPORTATION	68,529	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	172,757	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	35,311	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	883,050					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	37,126	0	0	11,849	580	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	261,324	0	0	84,019	4,084	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,499,563	0	0	95,868	4,664	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-6 Part I | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	1,051				10.00
11.00	MEDICAL RECORDS	0		1,174			11.00
12.00	STAFF TRANSPORTATION	0			169,823		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	169,823	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	985	1,101	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	8	9	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	58	64	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	1,051	1,174	169,823	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-6 Part I | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	428,111					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				87,504		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		169,823	50.00
51.00	HOSPICE ROUTINE HOME CARE	401,327	0	0		2,591,712	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,331	0	0	10,882	118,662	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	23,453	0	0	76,622	835,891	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	428,111	0	0	87,504	3,716,088	100.00

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

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6
Part II
Date/Time Prepared:
6/8/2020 3:16 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	400					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		445				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,303,131			3.00
4.00	ADMINISTRATIVE & GENERAL	400	0	623,562	-1,499,563	2,216,525	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	57,182	7.00
8.00	DIETARY	0	0	0	0	2,782	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	627	10.00
11.00	MEDICAL RECORDS	0	0	0	0	700	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	101,294	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	255,354	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	52,193	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			353,981	0	1,305,249	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	55	40,503	0	54,877	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	390	285,085	0	386,267	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	10,893	2,126	355,987		1,499,563	100.00
101.00	UNIT COST MULTIPLIER	27.232500	4.777528	0.273178		0.676538	101.00

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

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		445			7.00
8.00	DIETARY	0		0	1,166		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	55	145	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	390	1,021	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	95,868	4,664	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	215.433708	4.000000	0.000000	101.00

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

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6
Part II
Date/Time Prepared:
6/8/2020 3:16 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	18,637					10.00
11.00	MEDICAL RECORDS		18,637				11.00
12.00	STAFF TRANSPORTATION			1,000			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	18,637	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1,000	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	17,471	17,471	0	0	17,471	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	145	145	0	0	145	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,021	1,021	0	0	1,021	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	1,051	1,174	169,823	0	428,111	100.00
101.00	UNIT COST MULTIPLIER	0.056393	0.062993	169.823000	0.000000	22.971025	101.00

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

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6
Part II
Date/Time Prepared:
6/8/2020 3:16 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	18,637				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			1,166		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	17,471	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	145	0	145		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,021	0	1,021		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	87,504		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	75.046312		101.00

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

Provider CCN: 15-0048 Hospice CCN: 15-1524

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

Worksheet O-7

Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.651884	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.342294	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	1.248292	0	0	0	5.00
6.00	LABORATORY	60.00	0.177235	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.000000	0	0	0	7.00
8.00	FAMILY PRACTICE	93.00	0.513842	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	ANCILLARY - OTHER	76.00	0.000000	0	0	0	10.00
10.97	CARDIAC REHABILITATION	76.97	0.679794	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	FAMILY PRACTICE	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	ANCILLARY - OTHER	0	0	0	0	0	10.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-8 | Date/Time Prepared: 6/8/2020 3:16 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			169,823	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			2,591,712	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			17,471	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			148.34	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	14,098	775		9.00
10.00	Program cost (line 8 times line 9)	2,091,297	114,964		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			118,662	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			145	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			818.36	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	122	1		14.00
15.00	Program cost (line 13 times line 14)	99,840	818		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			835,891	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			1,021	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			818.70	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	795	49		19.00
20.00	Program cost (line 18 times line 19)	650,867	40,116		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,716,088	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			18,637	22.00
23.00	Average cost per diem (line 21 divided by line 22)			199.39	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 6/8/2020 3:16 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	4,106,324	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	140,286	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)	119.81	3.00
4.00	Number of interns & residents (see instructions)	15.47	4.00
5.00	Indirect medical education percentage (see instructions)	3.71	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)	152,345	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)	4,398,955	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