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: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/9/2020 1:42 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/9/2020 Time: 1:42 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL CLINTON (15-1326) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MATT NEALON
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-70,066	282,691	0	-11,578	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	40,860	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-29,206	282,691	0	-11,578	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: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 7/9/2020 1:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: CLINTON	State: IN	Zip Code: 47842-	County: VERMILLION	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	UNION HOSPITAL CLINTON	151326	45460	1	03/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BEDS	15Z326	45460		03/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/9/2020 1:42 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/9/2020 1:42 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 7/9/2020 1:42 pm

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/9/2020 1:42 pm

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	120,296	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/9/2020 1:42 pm

		1.00	2.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H043	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: UNION HOSPITAL, INC.	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1606 NORTH SEVENTH ST	PO Box:		142.00
143.00	City: TERRE HAUTE	State: IN	Zip Code: 47804	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/9/2020 1:42 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 7/9/2020 1:42 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		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.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/22/2020	Y	03/22/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 7/9/2020 1:42 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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CAROLYN	CHAPLIN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137919	CCHAPLIN@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/9/2020 1:42 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 MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 7/9/2020 1:42 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	19	6,935	30,744.00	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)		19	6,935	30,744.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	6,288.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	37,032.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 7/9/2020 1:42 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)	743	15	1,276			1.00
2.00	HMO and other (see instructions)	96	13				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	186	0	186			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	37			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	929	15	1,499			7.00
8.00	INTENSIVE CARE UNIT	143	0	262			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)	1,072	15	1,761	0.00	109.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	109.73	27.00
28.00	Observation Bed Days		125	964			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 7/9/2020 1:42 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	338	7	584	1.00
2.00	HMO and other (see instructions)			29	4		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	338	7	584	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 7/9/2020 1:42 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)	0.324277	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	519,953	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	15,979,865	6.00
7.00	Medicaid cost (line 1 times line 6)	5,181,903	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)	4,661,950	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)	4,661,950	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)	1,459,753	0	1,459,753	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	473,364	0	473,364	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)	473,364	0	473,364	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)	3,632,949	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	823,036	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,266,210	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,366,739	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,210,653	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,684,017	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,345,967	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 7/9/2020 1:42 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		739,368	739,368	-35,081	704,287	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		376,949	376,949	-1,198	375,751	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	29,074	29,074	0	29,074	5.01
5.02	00550	DATA PROCESSING	0	544,320	544,320	0	544,320	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	34,432	34,432	0	34,432	5.03
5.04	00570	ADMITTING	378,502	50,412	428,914	0	428,914	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	21,726	261,827	283,553	0	283,553	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	720,591	2,336,483	3,057,074	0	3,057,074	5.06
7.00	00700	OPERATION OF PLANT	370,682	753,855	1,124,537	0	1,124,537	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	205,561	63,049	268,610	0	268,610	9.00
10.00	01000	DIETARY	301,063	225,714	526,777	-427,312	99,465	10.00
11.00	01100	CAFETERIA	0	0	0	427,312	427,312	11.00
13.00	01300	NURSING ADMINISTRATION	597,940	103,028	700,968	0	700,968	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116,832	82,469	199,301	0	199,301	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	852,604	669,806	1,522,410	0	1,522,410	30.00
31.00	03100	INTENSIVE CARE UNIT	434,234	104,030	538,264	0	538,264	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	153,894	305,912	459,806	30,602	490,408	50.00
51.00	05100	RECOVERY ROOM	124,388	27,787	152,175	0	152,175	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,535	712,403	1,406,938	0	1,406,938	54.00
56.00	05600	RADIOISOTOPE	0	668	668	0	668	56.00
60.00	06000	LABORATORY	0	805,455	805,455	0	805,455	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25,013	25,013	0	25,013	62.00
65.00	06500	RESPIRATORY THERAPY	425,128	106,286	531,414	14,876	546,290	65.00
66.00	06600	PHYSICAL THERAPY	0	992,201	992,201	0	992,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,135	7,135	0	7,135	67.00
68.00	06800	SPEECH PATHOLOGY	0	50,674	50,674	0	50,674	68.00
69.00	06900	ELECTROCARDIOLOGY	26,124	330,404	356,528	0	356,528	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71,050	71,050	-68,578	2,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,040	16,040	0	16,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	242,809	721,996	964,805	0	964,805	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	972,481	2,651,797	3,624,278	23,100	3,647,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,639,094	13,199,637	19,838,731	-36,279	19,802,452	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	36,279	36,279	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	6,639,094	13,199,637	19,838,731	0	19,838,731	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 7/9/2020 1:42 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	1,074,017	1,778,304		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	375,751		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,147,467	1,147,467		4.00
5.01	00540	NONPATIENT TELEPHONES	26,775	55,849		5.01
5.02	00550	DATA PROCESSING	2,183,202	2,727,522		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	67,325	101,757		5.03
5.04	00570	ADMITTING	0	428,914		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	321,437	604,990		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	-737,562	2,319,512		5.06
7.00	00700	OPERATION OF PLANT	494,321	1,618,858		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	23,683	292,293		9.00
10.00	01000	DIETARY	10,132	109,597		10.00
11.00	01100	CAFETERIA	-100,293	327,019		11.00
13.00	01300	NURSING ADMINISTRATION	66,492	767,460		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,797	211,098		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-544,144	978,266		30.00
31.00	03100	INTENSIVE CARE UNIT	0	538,264		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-34,614	455,794		50.00
51.00	05100	RECOVERY ROOM	1,275	153,450		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,836	1,421,774		54.00
56.00	05600	RADIOISOTOPE	0	668		56.00
60.00	06000	LABORATORY	0	805,455		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25,013		62.00
65.00	06500	RESPIRATORY THERAPY	0	546,290		65.00
66.00	06600	PHYSICAL THERAPY	-358,634	633,567		66.00
67.00	06700	OCCUPATIONAL THERAPY	137,989	145,124		67.00
68.00	06800	SPEECH PATHOLOGY	-6,182	44,492		68.00
69.00	06900	ELECTROCARDIOLOGY	673	357,201		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,472		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,040		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,491	1,005,296		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-55,556	3,591,822		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,784,927	23,587,379		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	36,279		194.01
194.02	07952	VPCHC	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	3,784,927	23,623,658		200.00

RECLASSIFICATIONS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 7/9/2020 1:42 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	244,217	183,095		1.00
	0		244,217	183,095		
	B - DEPRECIATION RECLASS					
1.00	MEDICAL OFFICE BUILDING	194.01	0	36,279		1.00
2.00		0.00	0	0		2.00
	0		0	36,279		
	C - CENTRAL SUPPLIES RECLASS					
1.00	OPERATING ROOM	50.00	0	30,602		1.00
2.00	RESPIRATORY THERAPY	65.00	0	14,876		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	736		3.00
4.00	EMERGENCY	91.00	0	23,100		4.00
	0		0	69,314		
500.00	Grand Total: Increases		244,217	288,688		500.00

RECLASSIFICATIONS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 7/9/2020 1:42 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	244,217	183,095	0		1.00
	0		244,217	183,095			
	B - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	35,081	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,198	9		2.00
	0		0	36,279			
	C - CENTRAL SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	69,314	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	69,314			
500.00	Grand Total: Decreases		244,217	288,688			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 7/9/2020 1:42 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	339,822	0	0	0	0	1.00
2.00	Land Improvements	269,938	4,390	0	4,390	0	2.00
3.00	Buildings and Fixtures	11,779,148	55,571	0	55,571	0	3.00
4.00	Building Improvements	1,645,471	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,960,479	81,192	0	81,192	2,142	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,994,858	141,153	0	141,153	2,142	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,994,858	141,153	0	141,153	2,142	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	339,822	0	1.00
2.00	Land Improvements	274,328	0	2.00
3.00	Buildings and Fixtures	11,834,719	0	3.00
4.00	Building Improvements	1,645,471	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,039,529	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,133,869	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	21,133,869	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 7/9/2020 1:42 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	739,017	0	351	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	376,949	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,115,966	0	351	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	739,368		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	376,949		2.00
3.00	Total (sum of lines 1-2)	0	1,116,317		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 7/9/2020 1:42 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	14,094,340	0	14,094,340	0.666908	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,039,529	0	7,039,529	0.333092	0	2.00
3.00	Total (sum of lines 1-2)	21,133,869	0	21,133,869	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,778,304	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	375,751	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,154,055	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,778,304	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	375,751	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,154,055	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 7/9/2020 1:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - 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)	B	-351	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-681,683			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	6,595,253			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - 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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 7/9/2020 1:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-937	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CHART FEE REVENUE	B	-57	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	MISCELLANEOUS REVENUE	B	-5,666	ADMINISTRATIVE AND GENERAL	5.06	0	33.01
33.02	CAFETERIA REVENUE	B	-144,440	CAFETERIA	11.00	0	33.02
33.03	CATERING REVENUE	B	-2,547	CAFETERIA	11.00	0	33.03
33.04	VPCHC	A	-5,683	HOUSEKEEPING	9.00	0	33.04
33.05	ADVERTISING	B	-4,343	ADMINISTRATIVE AND GENERAL	5.06	0	33.05
35.00	RENTAL REVENUE	B	-157,836	OPERATION OF PLANT	7.00	0	35.00
36.00	HAF	A	-1,749,227	ADMINISTRATIVE AND GENERAL	5.06	0	36.00
39.00	PHYSICIAN RECRUITMENT	A	-2,000	ADMINISTRATIVE AND GENERAL	5.06	0	39.00
39.01	PHYSICIAN RECRUITMENT	A	-55,556	EMERGENCY	91.00	0	39.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,784,927				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: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 7/9/2020 1:42 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	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	1,075,305	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,147,467	0	2.00
3.00	5.01	NONPATIENT TELEPHONES	HOME OFFICE	26,775	0	3.00
3.01	5.02	DATA PROCESSING	HOME OFFICE	2,183,202	0	3.01
4.00	5.03	PURCHASING RECEIVING AND STO	HOME OFFICE	67,325	0	4.00
4.01	5.05	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	321,437	0	4.01
4.02	5.06	ADMINISTRATIVE AND GENERAL	HOME OFFICE	1,023,674	0	4.02
4.03	7.00	OPERATION OF PLANT	HOME OFFICE	652,157	0	4.03
4.04	9.00	HOUSEKEEPING	HOME OFFICE	29,366	0	4.04
4.05	10.00	DIETARY	HOME OFFICE	10,132	0	4.05
4.06	11.00	CAFETERIA	HOME OFFICE	46,694	0	4.06
4.07	13.00	NURSING ADMINISTRATION	HOME OFFICE	66,492	0	4.07
4.08	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	11,854	0	4.08
4.09	50.00	OPERATING ROOM	HOME OFFICE	3,148	0	4.09
4.10	50.00	OPERATING ROOM	HOME OFFICE	10,580	0	4.10
4.11	51.00	RECOVERY ROOM	HOME OFFICE	1,275	0	4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	104,033	0	4.12
4.13	66.00	PHYSICAL THERAPY	HOME OFFICE	39,722	0	4.13
4.14	67.00	OCCUPATIONAL THERAPY	HOME OFFICE	10,386	0	4.14
4.15	68.00	SPEECH PATHOLOGY	HOME OFFICE	2,533	0	4.15
4.16	69.00	ELECTROCARDIOLOGY	HOME OFFICE	673	0	4.16
4.17	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	40,491	0	4.17
4.18	66.00	PHYSICAL THERAPY	THERAPY	488,046	886,402	4.18
4.19	67.00	OCCUPATIONAL THERAPY	THERAPY	127,603	0	4.19
4.20	68.00	SPEECH PATHOLOGY	THERAPY	31,127	39,842	4.20
5.00	0		0	7,521,497	926,244	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	G		0.00	UNION HOSPITAL	100.00	6.00
7.00	G		0.00	UNION THERAPY	51.00	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:	OTHER				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: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 7/9/2020 1:42 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	1,075,305	9		1.00
2.00	1,147,467	0		2.00
3.00	26,775	0		3.00
3.01	2,183,202	0		3.01
4.00	67,325	0		4.00
4.01	321,437	0		4.01
4.02	1,023,674	0		4.02
4.03	652,157	0		4.03
4.04	29,366	0		4.04
4.05	10,132	0		4.05
4.06	46,694	0		4.06
4.07	66,492	0		4.07
4.08	11,854	0		4.08
4.09	3,148	0		4.09
4.10	10,580	0		4.10
4.11	1,275	0		4.11
4.12	104,033	0		4.12
4.13	39,722	0		4.13
4.14	10,386	0		4.14
4.15	2,533	0		4.15
4.16	673	0		4.16
4.17	40,491	0		4.17
4.18	-398,356	0		4.18
4.19	127,603	0		4.19
4.20	-8,715	0		4.20
5.00	6,595,253			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	HOME OFFICE		6.00
7.00	THERAPY		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: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 7/9/2020 1:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	544,144	544,144	0	0	0	1.00
2.00	50.00	OPERATING ROOM	48,342	48,342	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	89,197	89,197	0	0	0	3.00
4.00	91.00	EMERGENCY	2,138,010	0	2,138,010	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,819,693	681,683	2,138,010		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	544,144		1.00
2.00	50.00	OPERATING ROOM	0	0	0	48,342		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	89,197		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	681,683		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,778,304	1,778,304				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	375,751		375,751			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,147,467	0	0	1,147,467		4.00
5.01	00540	NONPATIENT TELEPHONES	55,849	2,385	5,497	0	63,731	5.01
5.02	00550	DATA PROCESSING	2,727,522	4,656	232,604	0	1,004	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	101,757	18,143	0	0	502	5.03
5.04	00570	ADMITTING	428,914	11,560	36	65,418	1,756	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	604,990	6,835	0	3,755	1,255	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	2,319,512	33,809	2,834	124,543	3,513	5.06
7.00	00700	OPERATION OF PLANT	1,618,858	492,819	5,561	64,067	5,520	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,496	136	0	0	8.00
9.00	00900	HOUSEKEEPING	292,293	8,991	1,937	35,528	251	9.00
10.00	01000	DIETARY	109,597	19,450	1,676	9,825	251	10.00
11.00	01100	CAFETERIA	327,019	82,939	7,142	42,209	1,505	11.00
13.00	01300	NURSING ADMINISTRATION	767,460	31,698	211	103,345	1,004	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	211,098	20,070	59	20,193	2,007	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	978,266	320,838	20,699	147,360	17,063	30.00
31.00	03100	INTENSIVE CARE UNIT	538,264	9,404	6,289	75,051	1,505	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	455,794	78,765	45,834	26,598	1,505	50.00
51.00	05100	RECOVERY ROOM	153,450	43,786	6,626	21,499	3,513	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,421,774	130,854	7,208	120,040	4,015	54.00
56.00	05600	RADIOISOTOPE	668	0	0	0	0	56.00
60.00	06000	LABORATORY	805,455	39,245	0	0	1,505	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	25,013	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	546,290	28,487	8,263	73,477	1,505	65.00
66.00	06600	PHYSICAL THERAPY	633,567	77,503	811	0	2,509	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,124	65,186	0	0	1,756	67.00
68.00	06800	SPEECH PATHOLOGY	44,492	8,808	0	0	502	68.00
69.00	06900	ELECTROCARDIOLOGY	357,201	9,610	467	4,515	1,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,472	229	0	0	251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,040	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,005,296	23,258	2,177	41,966	1,505	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,591,822	199,480	19,684	168,078	7,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,587,379	1,778,304	375,751	1,147,467	63,731	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	36,279	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	23,623,658	1,778,304	375,751	1,147,467	63,731	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	2,965,786					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	120,402				5.03
5.04	00570	ADMITTING	156,094	2,239	666,017			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	52,031	0	0	668,866		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	338,204	105	0	0	2,822,520	5.06
7.00	00700	OPERATION OF PLANT	676,406	41	0	0	2,863,272	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	9,632	8.00
9.00	00900	HOUSEKEEPING	26,016	10,799	0	0	375,815	9.00
10.00	01000	DIETARY	26,016	13	0	0	166,828	10.00
11.00	01100	CAFETERIA	52,031	56	0	0	512,901	11.00
13.00	01300	NURSING ADMINISTRATION	104,063	20	0	0	1,007,801	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	208,125	16	0	0	461,568	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	286,172	16,283	274,906	35,773	2,097,360	30.00
31.00	03100	INTENSIVE CARE UNIT	26,016	5,708	57,091	7,429	726,757	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	104,063	28,451	27,184	34,049	802,243	50.00
51.00	05100	RECOVERY ROOM	26,016	7,094	840	13,814	276,638	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	234,141	12,952	61,741	193,757	2,186,482	54.00
56.00	05600	RADIOISOTOPE	0	1	0	17	686	56.00
60.00	06000	LABORATORY	26,016	0	73,644	84,720	1,030,585	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1,632	792	27,437	62.00
65.00	06500	RESPIRATORY THERAPY	52,031	3,011	44,173	11,674	768,911	65.00
66.00	06600	PHYSICAL THERAPY	104,063	224	8,014	23,918	850,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1	3,746	6,254	222,067	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	756	1,525	56,083	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	23,002	33,630	429,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4	21	2,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	16,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,047	258	49,452	45,228	1,247,187	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	390,235	33,130	39,832	176,265	4,625,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,965,786	120,402	666,017	668,866	23,587,379	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	36,279	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	2,965,786	120,402	666,017	668,866	23,623,658	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			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
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	00591	ADMINISTRATIVE AND GENERAL	2,822,520					5.06
7.00	00700	OPERATION OF PLANT	388,520	3,251,792				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,307	25,559	36,498			8.00
9.00	00900	HOUSEKEEPING	50,995	24,201	2,946	453,957		9.00
10.00	01000	DIETARY	22,637	52,354	150	7,422	249,391	10.00
11.00	01100	CAFETERIA	69,596	223,244	531	31,650	0	11.00
13.00	01300	NURSING ADMINISTRATION	136,750	85,322	0	12,096	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,631	54,021	0	7,659	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	284,593	863,589	8,579	122,431	192,907	30.00
31.00	03100	INTENSIVE CARE UNIT	98,614	25,313	4,173	3,589	33,625	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108,857	212,008	1,132	30,057	0	50.00
51.00	05100	RECOVERY ROOM	37,537	117,857	0	16,709	22,859	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,686	352,214	3,660	49,934	0	54.00
56.00	05600	RADIOISOTOPE	93	0	0	0	0	56.00
60.00	06000	LABORATORY	139,841	105,633	0	14,976	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,723	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	104,334	76,678	170	10,871	0	65.00
66.00	06600	PHYSICAL THERAPY	115,420	208,612	3,505	29,575	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,132	175,459	0	24,875	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,610	23,707	0	3,361	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,270	25,868	759	3,667	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	404	617	0	88	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,176	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,232	62,602	0	8,875	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	627,639	536,934	10,893	76,122	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,817,597	3,251,792	36,498	453,957	249,391	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	4,923	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	2,822,520	3,251,792	36,498	453,957	249,391	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	00591	ADMINISTRATIVE AND GENERAL						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	837,922					11.00
13.00	01300	NURSING ADMINISTRATION	87,552	1,329,521				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,917	0	617,796			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	168,417	549,957	33,041	4,320,874	0	30.00
31.00	03100	INTENSIVE CARE UNIT	65,727	214,637	6,862	1,179,297	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,557	0	31,449	1,219,303	0	50.00
51.00	05100	RECOVERY ROOM	23,969	0	12,759	508,328	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	133,472	0	178,962	3,201,410	0	54.00
56.00	05600	RADIOISOTOPE	0	0	16	795	0	56.00
60.00	06000	LABORATORY	0	0	78,252	1,369,287	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	732	31,892	0	62.00
65.00	06500	RESPIRATORY THERAPY	74,431	0	10,782	1,046,177	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	22,092	1,229,813	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,776	458,309	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,409	92,170	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,415	0	31,062	553,470	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20	4,106	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,216	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,379	0	41,775	1,571,050	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	173,086	564,927	162,807	6,777,959	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	837,922	1,329,521	617,796	23,582,456	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	41,202	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	837,922	1,329,521	617,796	23,623,658	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
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	00591	ADMINISTRATIVE AND GENERAL			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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,320,874		30.00
31.00	03100	INTENSIVE CARE UNIT	1,179,297		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,219,303		50.00
51.00	05100	RECOVERY ROOM	508,328		51.00
51.01	05101	O/P TREATMENT ROOM	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,201,410		54.00
56.00	05600	RADIOISOTOPE	795		56.00
60.00	06000	LABORATORY	1,369,287		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,892		62.00
65.00	06500	RESPIRATORY THERAPY	1,046,177		65.00
66.00	06600	PHYSICAL THERAPY	1,229,813		66.00
67.00	06700	OCCUPATIONAL THERAPY	458,309		67.00
68.00	06800	SPEECH PATHOLOGY	92,170		68.00
69.00	06900	ELECTROCARDIOLOGY	553,470		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,106		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,216		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,571,050		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	6,777,959		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,582,456		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	41,202		194.01
194.02	07952	VPCHC	0		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	23,623,658		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	2,385	5,497	7,882	0	5.01
5.02	00550	DATA PROCESSING	0	4,656	232,604	237,260	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	18,143	0	18,143	0	5.03
5.04	00570	ADMITTING	0	11,560	36	11,596	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	6,835	0	6,835	0	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	0	33,809	2,834	36,643	0	5.06
7.00	00700	OPERATION OF PLANT	0	492,819	5,561	498,380	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,496	136	9,632	0	8.00
9.00	00900	HOUSEKEEPING	0	8,991	1,937	10,928	0	9.00
10.00	01000	DIETARY	0	19,450	1,676	21,126	0	10.00
11.00	01100	CAFETERIA	0	82,939	7,142	90,081	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,698	211	31,909	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,070	59	20,129	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	320,838	20,699	341,537	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,404	6,289	15,693	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,765	45,834	124,599	0	50.00
51.00	05100	RECOVERY ROOM	0	43,786	6,626	50,412	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	130,854	7,208	138,062	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	39,245	0	39,245	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	28,487	8,263	36,750	0	65.00
66.00	06600	PHYSICAL THERAPY	0	77,503	811	78,314	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	65,186	0	65,186	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,808	0	8,808	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,610	467	10,077	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	229	0	229	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,258	2,177	25,435	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	199,480	19,684	219,164	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,778,304	375,751	2,154,055	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,778,304	375,751	2,154,055	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 7/9/2020 1:42 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
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	7,882					5.01
5.02	00550	DATA PROCESSING	124	237,384				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	62	0	18,205			5.03
5.04	00570	ADMITTING	217	12,494	339	24,646		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	155	4,165	0	0	11,155	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	434	27,070	16	0	0	5.06
7.00	00700	OPERATION OF PLANT	683	54,141	6	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	31	2,082	1,633	0	0	9.00
10.00	01000	DIETARY	31	2,082	2	0	0	10.00
11.00	01100	CAFETERIA	186	4,165	8	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	124	8,329	3	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	248	16,659	2	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,113	22,905	2,462	10,171	595	30.00
31.00	03100	INTENSIVE CARE UNIT	186	2,082	863	2,113	124	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	186	8,329	4,302	1,006	567	50.00
51.00	05100	RECOVERY ROOM	434	2,082	1,073	31	230	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	497	18,741	1,958	2,285	3,249	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	186	2,082	0	2,726	1,410	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	60	13	62.00
65.00	06500	RESPIRATORY THERAPY	186	4,165	455	1,635	194	65.00
66.00	06600	PHYSICAL THERAPY	310	8,329	34	297	398	66.00
67.00	06700	OCCUPATIONAL THERAPY	217	0	0	139	104	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	0	28	25	68.00
69.00	06900	ELECTROCARDIOLOGY	124	0	0	851	560	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	186	6,247	39	1,830	753	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	869	31,235	5,010	1,474	2,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,882	237,384	18,205	24,646	11,155	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	7,882	237,384	18,205	24,646	11,155	202.00

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		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			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
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	00591	ADMINISTRATIVE AND GENERAL	64,163					5.06
7.00	00700	OPERATION OF PLANT	8,833	562,043				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30	4,418	14,080			8.00
9.00	00900	HOUSEKEEPING	1,159	4,183	1,136	21,152		9.00
10.00	01000	DIETARY	515	9,049	58	346	33,209	10.00
11.00	01100	CAFETERIA	1,582	38,586	205	1,475	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,109	14,747	0	564	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,424	9,337	0	357	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,470	149,262	3,310	5,702	25,688	30.00
31.00	03100	INTENSIVE CARE UNIT	2,242	4,375	1,610	167	4,477	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,475	36,644	437	1,400	0	50.00
51.00	05100	RECOVERY ROOM	853	20,371	0	779	3,044	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,745	60,877	1,412	2,327	0	54.00
56.00	05600	RADIOISOTOPE	2	0	0	0	0	56.00
60.00	06000	LABORATORY	3,179	18,258	0	698	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	85	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,372	13,253	65	507	0	65.00
66.00	06600	PHYSICAL THERAPY	2,624	36,057	1,352	1,378	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	685	30,326	0	1,159	0	67.00
68.00	06800	SPEECH PATHOLOGY	173	4,098	0	157	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,325	4,471	293	171	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9	107	0	4	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,848	10,820	0	414	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	14,263	92,804	4,202	3,547	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,051	562,043	14,080	21,152	33,209	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	112	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	64,163	562,043	14,080	21,152	33,209	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	00591	ADMINISTRATIVE AND GENERAL						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	136,288					11.00
13.00	01300	NURSING ADMINISTRATION	14,240	73,025				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,191	0	53,347			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,393	30,207	2,852	630,667	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,690	11,789	592	57,003	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,458	0	2,715	188,118	0	50.00
51.00	05100	RECOVERY ROOM	3,899	0	1,101	84,309	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,709	0	15,468	273,330	0	54.00
56.00	05600	RADIOISOTOPE	0	0	1	3	0	56.00
60.00	06000	LABORATORY	0	0	6,754	74,538	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	63	221	0	62.00
65.00	06500	RESPIRATORY THERAPY	12,106	0	931	72,619	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,907	131,000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	499	98,315	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	122	13,473	0	68.00
69.00	06900	ELECTROCARDIOLOGY	718	0	2,681	21,271	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2	382	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	49	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,730	0	3,606	59,908	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	28,154	31,029	14,053	448,737	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,288	73,025	53,347	2,153,943	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	112	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	136,288	73,025	53,347	2,154,055	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
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	00591	ADMINISTRATIVE AND GENERAL			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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	630,667		30.00
31.00	03100	INTENSIVE CARE UNIT	57,003		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	188,118		50.00
51.00	05100	RECOVERY ROOM	84,309		51.00
51.01	05101	O/P TREATMENT ROOM	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	273,330		54.00
56.00	05600	RADIOISOTOPE	3		56.00
60.00	06000	LABORATORY	74,538		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	221		62.00
65.00	06500	RESPIRATORY THERAPY	72,619		65.00
66.00	06600	PHYSICAL THERAPY	131,000		66.00
67.00	06700	OCCUPATIONAL THERAPY	98,315		67.00
68.00	06800	SPEECH PATHOLOGY	13,473		68.00
69.00	06900	ELECTROCARDIOLOGY	21,271		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	382		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,908		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	448,737		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,153,943		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	112		194.01
194.02	07952	VPCHC	0		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,154,055		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQ FT)	NEW MVBLE EQUIP (EQUIP DEPRN)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	77,531					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		364,855				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,639,094			4.00
5.01	00540	NONPATIENT TELEPHONES	104	5,338	0	254		5.01
5.02	00550	DATA PROCESSING	203	225,859	0	4	114	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	791	0	0	2	0	5.03
5.04	00570	ADMITTING	504	35	378,502	7	6	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	298	0	21,726	5	2	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,474	2,752	720,591	14	13	5.06
7.00	00700	OPERATION OF PLANT	21,486	5,400	370,682	22	26	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	132	0	0	0	8.00
9.00	00900	HOUSEKEEPING	392	1,881	205,561	1	1	9.00
10.00	01000	DIETARY	848	1,627	56,846	1	1	10.00
11.00	01100	CAFETERIA	3,616	6,935	244,217	6	2	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	205	597,940	4	4	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	57	116,832	8	8	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	20,099	852,604	68	11	30.00
31.00	03100	INTENSIVE CARE UNIT	410	6,107	434,234	6	1	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,434	44,505	153,894	6	4	50.00
51.00	05100	RECOVERY ROOM	1,909	6,434	124,388	14	1	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,705	6,999	694,535	16	9	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,711	0	0	6	1	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,242	8,023	425,128	6	2	65.00
66.00	06600	PHYSICAL THERAPY	3,379	787	0	10	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	0	7	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	453	26,124	4	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10	0	0	1	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,014	2,114	242,809	6	3	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,697	19,113	972,481	28	15	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,531	364,855	6,639,094	254	114	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,778,304	375,751	1,147,467	63,731	2,965,786	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.936683	1.029864	0.172835	250.909449	26,015.666667	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	7,882	237,384	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	31.031496	2,082.315789	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: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (REQUISITIO)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	259,361					5.03
5.04	00570	ADMITTING	4,824	9,426,389				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	72,748,248			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	226	0	0	-2,822,520	20,801,138	5.06
7.00	00700	OPERATION OF PLANT	88	0	0	0	2,863,272	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	9,632	8.00
9.00	00900	HOUSEKEEPING	23,262	0	0	0	375,815	9.00
10.00	01000	DIETARY	28	0	0	0	166,828	10.00
11.00	01100	CAFETERIA	121	0	0	0	512,901	11.00
13.00	01300	NURSING ADMINISTRATION	43	0	0	0	1,007,801	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34	0	0	0	461,568	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,076	3,890,895	3,890,895	0	2,097,360	30.00
31.00	03100	INTENSIVE CARE UNIT	12,296	808,020	808,020	0	726,757	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,288	384,736	3,703,392	0	802,243	50.00
51.00	05100	RECOVERY ROOM	15,281	11,895	1,502,481	0	276,638	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,900	873,831	21,072,246	0	2,186,482	54.00
56.00	05600	RADIOISOTOPE	2	0	1,828	0	686	56.00
60.00	06000	LABORATORY	0	1,042,308	9,214,752	0	1,030,585	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	23,100	86,159	0	27,437	62.00
65.00	06500	RESPIRATORY THERAPY	6,485	625,190	1,269,715	0	768,911	65.00
66.00	06600	PHYSICAL THERAPY	483	113,429	2,601,486	0	850,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	2	53,018	680,175	0	222,067	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,695	165,919	0	56,083	68.00
69.00	06900	ELECTROCARDIOLOGY	0	325,550	3,657,783	0	429,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	60	2,324	0	2,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	16,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	556	699,903	4,919,290	0	1,247,187	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	71,366	563,759	19,171,783	0	4,625,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	259,361	9,426,389	72,748,248	-2,822,520	20,764,859	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	36,279	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	120,402	666,017	668,866		2,822,520	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.464226	0.070655	0.009194		0.135691	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,205	24,646	11,155		64,163	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.070192	0.002615	0.000153		0.003085	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: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NUMBER HOUSED)	DIETARY (DIETARY)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	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	00591	ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	52,671					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	61,075				8.00
9.00	00900	HOUSEKEEPING	392	4,929	51,865			9.00
10.00	01000	DIETARY	848	251	848	5,444		10.00
11.00	01100	CAFETERIA	3,616	889	3,616	0	6,642	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	0	1,382	0	694	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	0	875	0	253	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	14,356	13,988	4,211	1,335	30.00
31.00	03100	INTENSIVE CARE UNIT	410	6,983	410	734	521	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,434	1,895	3,434	0	266	50.00
51.00	05100	RECOVERY ROOM	1,909	0	1,909	499	190	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,705	6,125	5,705	0	1,058	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,711	0	1,711	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,242	284	1,242	0	590	65.00
66.00	06600	PHYSICAL THERAPY	3,379	5,866	3,379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	2,842	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	384	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	1,270	419	0	35	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10	0	10	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,014	0	1,014	0	328	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,697	18,227	8,697	0	1,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,671	61,075	51,865	5,444	6,642	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,251,792	36,498	453,957	249,391	837,922	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	61.737806	0.597593	8.752666	45.810250	126.155074	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	562,043	14,080	21,152	33,209	136,288	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.670825	0.230536	0.407828	6.100110	20.519121	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: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/9/2020 1:42 pm

		Cost Center Description	NURSING ADMINISTRATION (TIME SPENT)	MEDICAL RECORDS & LIBRARY (ASSIGNED TIME)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
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	00591	ADMINISTRATIVE AND GENERAL				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	67,146			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72,748,248		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	27,775	3,890,895		30.00
31.00	03100	INTENSIVE CARE UNIT	10,840	808,020		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,703,392		50.00
51.00	05100	RECOVERY ROOM	0	1,502,481		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,072,246		54.00
56.00	05600	RADIOISOTOPE	0	1,828		56.00
60.00	06000	LABORATORY	0	9,214,752		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	86,159		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,269,715		65.00
66.00	06600	PHYSICAL THERAPY	0	2,601,486		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	680,175		67.00
68.00	06800	SPEECH PATHOLOGY	0	165,919		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,657,783		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,324		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,919,290		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	28,531	19,171,783		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,146	72,748,248		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
194.02	07952	VPCHC	0	0		194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,329,521	617,796		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.800450	0.008492		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,025	53,347		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.087555	0.000733		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,320,874		4,320,874	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,179,297		1,179,297	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,219,303		1,219,303	0	0	50.00
51.00	05100	RECOVERY ROOM	508,328		508,328	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0		0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,201,410		3,201,410	0	0	54.00
56.00	05600	RADIOISOTOPE	795		795	0	0	56.00
60.00	06000	LABORATORY	1,369,287		1,369,287	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,892		31,892	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,046,177	0	1,046,177	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,229,813	0	1,229,813	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	458,309	0	458,309	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	92,170	0	92,170	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	553,470		553,470	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,106		4,106	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,216		18,216	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,571,050		1,571,050	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,777,959		6,777,959	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,715,052		1,715,052		0	92.00
200.00		Subtotal (see instructions)	25,297,508	0	25,297,508	0	0	200.00
201.00		Less Observation Beds	1,715,052		1,715,052		0	201.00
202.00		Total (see instructions)	23,582,456	0	23,582,456	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,639,575		2,639,575			30.00
31.00	03100	INTENSIVE CARE UNIT	666,292		666,292			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	384,736	3,282,812	3,667,548	0.332457	0.000000	50.00
51.00	05100	RECOVERY ROOM	11,895	1,463,770	1,475,665	0.344474	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0.000000	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	873,831	20,198,415	21,072,246	0.151925	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	1,828	1,828	0.434902	0.000000	56.00
60.00	06000	LABORATORY	1,042,308	8,172,444	9,214,752	0.148597	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	23,100	63,059	86,159	0.370153	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	625,190	644,525	1,269,715	0.823946	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	113,429	2,488,057	2,601,486	0.472735	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,018	627,157	680,175	0.673810	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	10,695	155,224	165,919	0.555512	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	325,550	3,332,233	3,657,783	0.151313	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60	2,264	2,324	1.766781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,844	35,844	0.508202	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	699,903	4,219,387	4,919,290	0.319365	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	563,759	18,608,024	19,171,783	0.353538	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,463	1,387,363	1,394,826	1.229581	0.000000	92.00
200.00		Subtotal (see instructions)	8,040,804	64,682,406	72,723,210			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,040,804	64,682,406	72,723,210			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	O/P TREATMENT ROOM	0.000000		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/9/2020 1:42 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	4,320,874		4,320,874	0	4,320,874	30.00
31.00	03100	INTENSIVE CARE UNIT	1,179,297		1,179,297	0	1,179,297	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,219,303		1,219,303	0	1,219,303	50.00
51.00	05100	RECOVERY ROOM	508,328		508,328	0	508,328	51.00
51.01	05101	O/P TREATMENT ROOM	0		0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,201,410		3,201,410	0	3,201,410	54.00
56.00	05600	RADIOISOTOPE	795		795	0	795	56.00
60.00	06000	LABORATORY	1,369,287		1,369,287	0	1,369,287	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,892		31,892	0	31,892	62.00
65.00	06500	RESPIRATORY THERAPY	1,046,177	0	1,046,177	0	1,046,177	65.00
66.00	06600	PHYSICAL THERAPY	1,229,813	0	1,229,813	0	1,229,813	66.00
67.00	06700	OCCUPATIONAL THERAPY	458,309	0	458,309	0	458,309	67.00
68.00	06800	SPEECH PATHOLOGY	92,170	0	92,170	0	92,170	68.00
69.00	06900	ELECTROCARDIOLOGY	553,470		553,470	0	553,470	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,106		4,106	0	4,106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,216		18,216	0	18,216	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,571,050		1,571,050	0	1,571,050	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,777,959		6,777,959	0	6,777,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,715,052		1,715,052		1,715,052	92.00
200.00		Subtotal (see instructions)	25,297,508	0	25,297,508	0	25,297,508	200.00
201.00		Less Observation Beds	1,715,052		1,715,052		1,715,052	201.00
202.00		Total (see instructions)	23,582,456	0	23,582,456	0	23,582,456	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/9/2020 1:42 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	2,639,575		2,639,575			30.00
31.00	03100	INTENSIVE CARE UNIT	666,292		666,292			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	384,736	3,282,812	3,667,548	0.332457	0.000000	50.00
51.00	05100	RECOVERY ROOM	11,895	1,463,770	1,475,665	0.344474	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0.000000	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	873,831	20,198,415	21,072,246	0.151925	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	1,828	1,828	0.434902	0.000000	56.00
60.00	06000	LABORATORY	1,042,308	8,172,444	9,214,752	0.148597	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	23,100	63,059	86,159	0.370153	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	625,190	644,525	1,269,715	0.823946	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	113,429	2,488,057	2,601,486	0.472735	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,018	627,157	680,175	0.673810	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	10,695	155,224	165,919	0.555512	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	325,550	3,332,233	3,657,783	0.151313	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60	2,264	2,324	1.766781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,844	35,844	0.508202	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	699,903	4,219,387	4,919,290	0.319365	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	563,759	18,608,024	19,171,783	0.353538	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,463	1,387,363	1,394,826	1.229581	0.000000	92.00
200.00		Subtotal (see instructions)	8,040,804	64,682,406	72,723,210			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,040,804	64,682,406	72,723,210			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/9/2020 1:42 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	O/P TREATMENT ROOM	0.000000		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,118	3,667,548	0.051293	193,809	9,941	50.00
51.00	05100	RECOVERY ROOM	84,309	1,475,665	0.057133	2,100	120	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	273,330	21,072,246	0.012971	220,410	2,859	54.00
56.00	05600	RADIOISOTOPE	3	1,828	0.001641	0	0	56.00
60.00	06000	LABORATORY	74,538	9,214,752	0.008089	447,883	3,623	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	221	86,159	0.002565	19,800	51	62.00
65.00	06500	RESPIRATORY THERAPY	72,619	1,269,715	0.057193	322,867	18,466	65.00
66.00	06600	PHYSICAL THERAPY	131,000	2,601,486	0.050356	63,688	3,207	66.00
67.00	06700	OCCUPATIONAL THERAPY	98,315	680,175	0.144544	24,143	3,490	67.00
68.00	06800	SPEECH PATHOLOGY	13,473	165,919	0.081202	7,205	585	68.00
69.00	06900	ELECTROCARDIOLOGY	21,271	3,657,783	0.005815	173,050	1,006	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	382	2,324	0.164372	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49	35,844	0.001367	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,908	4,919,290	0.012178	342,434	4,170	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	448,737	19,171,783	0.023406	3,018	71	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	250,326	1,394,826	0.179468	0	0	92.00
200.00		Total (lines 50 through 199)	1,716,599	69,417,343		1,820,407	47,589	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,667,548	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,475,665	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,072,246	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	1,828	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	9,214,752	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	86,159	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,269,715	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,601,486	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	680,175	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	165,919	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,657,783	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,324	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,844	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,919,290	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	19,171,783	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,394,826	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	69,417,343		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	193,809	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,100	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	220,410	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	447,883	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	19,800	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	322,867	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	63,688	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	24,143	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,205	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	173,050	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	342,434	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,018	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,820,407	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.332457	0	1,025,871	0	0	50.00
51.00	05100	RECOVERY ROOM	0.344474	0	594,877	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151925	0	6,171,340	556	0	54.00
56.00	05600	RADIOISOTOPE	0.434902	0	0	0	0	56.00
60.00	06000	LABORATORY	0.148597	0	2,925,766	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.370153	0	59,191	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.823946	0	230,324	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.472735	0	1,097,082	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.673810	0	237,536	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.555512	0	16,699	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151313	0	1,383,734	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.766781	0	1,213	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508202	0	17,482	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319365	0	1,365,358	3,152	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.353538	0	4,536,385	2,226	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.229581	0	591,615	0	0	92.00
200.00		Subtotal (see instructions)		0	20,254,473	5,934	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	20,254,473	5,934	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	341,058	0		50.00
51.00	05100	RECOVERY ROOM	204,920	0		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	937,581	84		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	434,760	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	21,910	0		62.00
65.00	06500	RESPIRATORY THERAPY	189,775	0		65.00
66.00	06600	PHYSICAL THERAPY	518,629	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	160,054	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,276	0		68.00
69.00	06900	ELECTROCARDIOLOGY	209,377	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,143	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,884	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	436,048	1,007		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,603,784	787		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	727,439	0		92.00
200.00		Subtotal (see instructions)	5,805,638	1,878		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,805,638	1,878		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.332457	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.344474	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151925	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.434902	0	0	0	0	56.00
60.00	06000	LABORATORY	0.148597	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.370153	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.823946	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.472735	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.673810	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.555512	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151313	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.766781	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508202	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319365	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.353538	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.229581	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,463	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,240	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,276	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	186	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	37	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	743	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)	186	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,320,874	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)	4,778	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)	335,691	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,985,183	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)	3,985,183	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)	1,779.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,321,871	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)	1,321,871	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,179,297	262	4,501.13	143	643,662	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	625,541	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,591,074	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)	330,913	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)	330,913	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)	964	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,779.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,715,052	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	630,667	4,320,874	0.145958	1,715,052	250,326	90.00
91.00	Nursing School cost	0	4,320,874	0.000000	1,715,052	0	91.00
92.00	Allied health cost	0	4,320,874	0.000000	1,715,052	0	92.00
93.00	All other Medical Education	0	4,320,874	0.000000	1,715,052	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/9/2020 1:42 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)	2,463	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,240	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,276	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	37	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	15	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,320,874	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)	4,778	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)	4,778	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,316,096	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)	4,316,096	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)	1,926.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	28,902	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)	28,902	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/9/2020 1:42 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,179,297	262	4,501.13	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)	21,491	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	50,393	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)	964	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,926.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,857,464	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/9/2020 1:42 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	630,667	4,320,874	0.145958	1,857,464	271,112	90.00
91.00	Nursing School cost	0	4,320,874	0.000000	1,857,464	0	91.00
92.00	Allied health cost	0	4,320,874	0.000000	1,857,464	0	92.00
93.00	All other Medical Education	0	4,320,874	0.000000	1,857,464	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,370,790		30.00
31.00	03100	INTENSIVE CARE UNIT		344,770		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.332457	193,809	64,433	50.00
51.00	05100	RECOVERY ROOM	0.344474	2,100	723	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151925	220,410	33,486	54.00
56.00	05600	RADIOISOTOPE	0.434902	0	0	56.00
60.00	06000	LABORATORY	0.148597	447,883	66,554	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.370153	19,800	7,329	62.00
65.00	06500	RESPIRATORY THERAPY	0.823946	322,867	266,025	65.00
66.00	06600	PHYSICAL THERAPY	0.472735	63,688	30,108	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.673810	24,143	16,268	67.00
68.00	06800	SPEECH PATHOLOGY	0.555512	7,205	4,002	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151313	173,050	26,185	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.766781	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508202	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319365	342,434	109,361	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.353538	3,018	1,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.229581	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,820,407	625,541	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,820,407		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.332457	35	12	50.00
51.00	05100	RECOVERY ROOM	0.344474	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151925	2,075	315	54.00
56.00	05600	RADIOISOTOPE	0.434902	0	0	56.00
60.00	06000	LABORATORY	0.148597	25,927	3,853	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.370153	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.823946	56,742	46,752	65.00
66.00	06600	PHYSICAL THERAPY	0.472735	23,639	11,175	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.673810	18,565	12,509	67.00
68.00	06800	SPEECH PATHOLOGY	0.555512	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151313	1,050	159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.766781	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508202	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319365	59,633	19,045	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.353538	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.229581	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		187,666	93,820	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)		187,666		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/9/2020 1:42 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		26,670		30.00
31.00	03100	INTENSIVE CARE UNIT		11,442		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.332457	7,227	2,403	50.00
51.00	05100	RECOVERY ROOM	0.344474	59	20	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151925	23,276	3,536	54.00
56.00	05600	RADIOISOTOPE	0.434902	0	0	56.00
60.00	06000	LABORATORY	0.148597	19,357	2,876	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.370153	315	117	62.00
65.00	06500	RESPIRATORY THERAPY	0.823946	3,966	3,268	65.00
66.00	06600	PHYSICAL THERAPY	0.472735	254	120	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.673810	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.555512	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151313	4,572	692	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.766781	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508202	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319365	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.353538	23,928	8,459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.229581	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		82,954	21,491	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)		82,954		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3

Component CCN: 15-Z326 | Date/Time Prepared: 7/9/2020 1:42 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.332457	0	0	50.00
51.00	05100	RECOVERY ROOM	0.344474	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151925	0	0	54.00
56.00	05600	RADIOISOTOPE	0.434902	0	0	56.00
60.00	06000	LABORATORY	0.148597	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.370153	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.823946	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.472735	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.673810	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.555512	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151313	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.766781	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508202	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319365	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.353538	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.229581	0	0	92.00
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: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part B Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,807,516	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,807,516	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,865,591	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	62,423	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,434,009	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)	2,369,159	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)	2,369,159	30.00
31.00	Primary payer payments	2,416	31.00
32.00	Subtotal (line 30 minus line 31)	2,366,743	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)	1,201,771	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	781,151	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	819,894	36.00
37.00	Subtotal (see instructions)	3,147,894	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,147,894	40.00
40.01	Sequestration adjustment (see instructions)	62,958	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,802,245	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	282,691	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,345,612		2,802,245	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)		2,345,612		2,802,245	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		282,691	6.01
6.02	SETTLEMENT TO PROGRAM		70,066		0	6.02
7.00	Total Medicare program liability (see instructions)		2,275,546		3,084,936	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: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		379,540		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		379,540		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		40,860		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		420,400		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 7/9/2020 1:42 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 7/9/2020 1:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	334,222	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	94,758	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	186	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	428,980	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	428,980	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	428,980	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	428,980	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	428,980	0	19.00
19.01	Sequestration adjustment (see instructions)	8,580	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	379,540	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	40,860	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1326 Component CCN: 15-Z326	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2 Date/Time Prepared: 7/9/2020 1:42 pm
	Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 7/9/2020 1:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,591,074	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,591,074	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,616,985	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,616,985	19.00
20.00	Deductibles (exclude professional component)	336,884	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,280,101	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,280,101	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	64,439	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	41,885	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	28,694	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,321,986	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,321,986	30.00
30.01	Sequestration adjustment (see instructions)	46,440	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,345,612	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-70,066	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII | Date/Time Prepared: 7/9/2020 1:42 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	50,393		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)	50,393	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)	50,393	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	38,112		8.00
9.00	Ancillary service charges	82,954	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)	121,066	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)	121,066	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	70,673	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)	50,393	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)	50,393	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)	50,393	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)	50,393	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	50,393	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)	50,393	0	40.00
41.00	Interim payments	61,971	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-11,578	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 7/9/2020 1:42 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	6,039	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,866,175	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	254,172	0	0	0	7.00
8.00	Prepaid expenses	37,202,786	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	39,329,172	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	614,150	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	13,480,190	0	0	0	15.00
16.00	Accumulated depreciation	-15,175,002	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,039,529	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,958,867	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,288,039	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	403,381	0	0	0	37.00
38.00	Salaries, wages, and fees payable	653,962	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	314,242	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,371,585	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,371,585	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	43,916,454				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)	43,916,454	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,288,039	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 7/9/2020 1:42 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		40,573,568		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,342,886				2.00
3.00	Total (sum of line 1 and line 2)		43,916,454		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)		43,916,454		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		43,916,454		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/9/2020 1:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,639,575		2,639,575	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,639,575		2,639,575	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	666,292		666,292	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)	666,292		666,292	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,305,867		3,305,867	17.00
18.00	Ancillary services	4,163,715	44,687,019	48,850,734	18.00
19.00	Outpatient services	571,222	19,995,387	20,566,609	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				26.00
27.00	PHYSICIAN REVENUE	0	25,038	25,038	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,040,804	64,707,444	72,748,248	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,838,731		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)		19,838,731		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 7/9/2020 1:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,748,248	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,457,702	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,290,546	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,838,731	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,451,815	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	359,348	24.00
24.01	OTHER	2,180	24.01
24.02	CHANGES IN UHF	9,793	24.02
24.03	INVESTMENT INCOME	1,040	24.03
25.00	Total other income (sum of lines 6-24)	372,361	25.00
26.00	Total (line 5 plus line 25)	4,824,176	26.00
27.00	ALLOCATED EXPENSES	1,481,290	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,481,290	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,342,886	29.00