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: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/28/2020 10:36 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/28/2020 Time: 10:36 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUKES MEMORIAL HOSPITAL (15-1318) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

VP, REVENUE MANAGEMENT
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	249,115	-1,004,606	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	40,637	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	289,752	-1,004,606	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/28/2020 10:36 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 275 WEST 12TH STREET	PO Box:			1.00
2.00	City: PERU	State: IN	Zip Code: 46970	County: MIAMI	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	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	O	P	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	DUKES MEMORIAL HOSPITAL SB	15Z318	99915		12/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	4		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			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.	101	0	0	0	634	9	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:36 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:36 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:36 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:36 am

					1.00	
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	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
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	11,882	44,130	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
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	HB1848	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:36 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 8/28/2020 10:36 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/20/2020	Y	03/20/2020	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 10:36 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	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.	Y	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.	CALEB	TUBBS	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7183	CALEB_TUBBS@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 10:36 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, REVENUE MANAGEMENT		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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2020 10:36 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	64,550.00	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)		21	7,665	64,550.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	9,690.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	74,240.00	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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2020 10:36 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,383	53	2,709			1.00
2.00	HMO and other (see instructions)	442	643				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	281	0	298			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	7			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,664	53	3,014			7.00
8.00	INTENSIVE CARE UNIT	221	11	407			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		37	333			13.00
14.00	Total (see instructions)	1,885	101	3,754	0.00	188.72	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)			8			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	188.72	27.00
28.00	Observation Bed Days		0	1,000			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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 8/28/2020 10:36 am

	Component	Full Time Equivalents Nonpaid Workers	Discharges 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	427	281	975	1.00
2.00	HMO and other (see instructions)			106	0		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	427	281	975	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 WAGE RELATED COSTS	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 8/28/2020 10:36 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	204,380	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	973,463	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	5,702	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,917	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	183	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	8,681	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	113,623	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	674,952	17.00
18.00	Medicare Taxes - Employers Portion Only	157,852	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	27,725	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,176,478	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/28/2020 10:36 am

Line	Description	1.00	Line
	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)	0.182433	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,427,273	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		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	38,610,240	6.00
7.00	Medicaid cost (line 1 times line 6)	7,043,782	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)	2,616,509	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)	2,616,509	19.00

Line	Description	Uninsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	Line
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,002,804	0	5,002,804	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	912,677	0	912,677	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)	912,677	0	912,677	23.00

Line	Description	1.00	Line
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,833,445	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	783,532	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,205,434	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,628,011	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	718,905	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,631,582	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,248,091	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		969,896	969,896	487,436	1,457,332	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,262,298	2,262,298	158,942	2,421,240	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	128,020	80,025	208,045	1,322,674	1,530,719	4.00
5.01	00570	ADMITTING	0	0	0	1,196,948	1,196,948	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	1,677,040	8,489,389	10,166,429	-2,909,055	7,257,374	5.02
7.00	00700	OPERATION OF PLANT	288,393	1,561,830	1,850,223	624,969	2,475,192	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,037	73,037	0	73,037	8.00
9.00	00900	HOUSEKEEPING	354,405	131,793	486,198	-2,062	484,136	9.00
10.00	01000	DIETARY	197,849	158,331	356,180	-208,975	147,205	10.00
11.00	01100	CAFETERIA	0	0	0	206,285	206,285	11.00
13.00	01300	NURSING ADMINISTRATION	670,125	90,106	760,231	-402,375	357,856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,789	187,667	268,456	-39,752	228,704	14.00
15.00	01500	PHARMACY	338,082	1,132,987	1,471,069	-973,403	497,666	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,659	210,318	272,977	-6,643	266,334	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	209,429	209,429	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,059,373	1,187,628	3,247,001	-286,820	2,960,181	30.00
31.00	03100	INTENSIVE CARE UNIT	401,416	57,098	458,514	-1,844	456,670	31.00
43.00	04300	NURSERY	0	384	384	266,230	266,614	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	468,943	1,027,986	1,496,929	-282,051	1,214,878	50.00
51.00	05100	RECOVERY ROOM	264,429	37,185	301,614	-3,485	298,129	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	115,981	115,981	0	115,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	400,347	196,455	596,802	491,337	1,088,139	54.00
54.01	05401	ULTRASOUND	98,243	15,612	113,855	-113,855	0	54.01
56.00	05600	RADIOISOTOPE	84,515	149,354	233,869	-233,869	0	56.00
57.00	05700	CT SCAN	169,876	150,196	320,072	-320,072	0	57.00
58.00	05800	MRI	85,447	94,339	179,786	-179,786	0	58.00
60.00	06000	LABORATORY	759,802	674,955	1,434,757	-68,824	1,365,933	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	81,584	81,584	0	81,584	62.00
65.00	06500	RESPIRATORY THERAPY	479,029	102,824	581,853	-21,165	560,688	65.00
66.00	06600	PHYSICAL THERAPY	486	421,642	422,128	-1,767	420,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	166,200	166,200	0	166,200	67.00
68.00	06800	SPEECH PATHOLOGY	0	66,133	66,133	0	66,133	68.00
69.00	06900	ELECTROCARDIOLOGY	192,024	40,429	232,453	-5,607	226,846	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	31,660	31,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	215,218	215,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	889,906	889,906	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	110,848	20,410	131,258	-5,235	126,023	90.00
91.00	09100	EMERGENCY	3,521,646	673,034	4,194,680	-7,273	4,187,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	299,265	174,593	473,858	-27,116	446,742	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,193,051	20,801,699	33,994,750	0	33,994,750	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	692	15,144	15,836	0	15,836	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	13,193,743	20,816,843	34,010,586	0	34,010,586	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	790,477	2,247,809	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	98,833	2,520,073	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,530,719	4.00
5.01	00570	ADMITTING	0	1,196,948	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	-355,000	6,902,374	5.02
7.00	00700	OPERATION OF PLANT	-12,387	2,462,805	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,037	8.00
9.00	00900	HOUSEKEEPING	0	484,136	9.00
10.00	01000	DIETARY	0	147,205	10.00
11.00	01100	CAFETERIA	-52,549	153,736	11.00
13.00	01300	NURSING ADMINISTRATION	-14,155	343,701	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	228,704	14.00
15.00	01500	PHARMACY	0	497,666	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,317	265,017	16.00
17.00	01700	SOCIAL SERVICE	0	209,429	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-774,724	2,185,457	30.00
31.00	03100	INTENSIVE CARE UNIT	0	456,670	31.00
43.00	04300	NURSERY	0	266,614	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-429,902	784,976	50.00
51.00	05100	RECOVERY ROOM	0	298,129	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-115,981	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,088,139	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	1,365,933	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	81,584	62.00
65.00	06500	RESPIRATORY THERAPY	0	560,688	65.00
66.00	06600	PHYSICAL THERAPY	0	420,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	166,200	67.00
68.00	06800	SPEECH PATHOLOGY	0	66,133	68.00
69.00	06900	ELECTROCARDIOLOGY	-1,507	225,339	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	31,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	215,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	889,906	73.00
76.00	03610	SLEEP LAB	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	126,023	90.00
91.00	09100	EMERGENCY	-331,833	3,855,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	446,742	95.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,200,045	32,794,705	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,836	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,200,045	32,810,541	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,325,901	1.00
	0		0	1,325,901	
	B - RENT AND LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	58,472	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	131,198	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	189,670	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	80,703	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	348,261	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27,744	3.00
	0		0	456,708	
	D - CNO COSTS				
1.00	NURSING ADMINISTRATION	13.00	122,423	0	1.00
	0		122,423	0	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	31,660	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	215,218	2.00
	0		0	246,878	
	F - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	889,906	1.00
	0		0	889,906	
	G - NURSERY				
1.00	NURSERY	43.00	234,238	32,376	1.00
	0		234,238	32,376	
	I - MISC DEPARTMENTS				
1.00	ADMITTING	5.01	529,661	667,287	1.00
	0		529,661	667,287	
	J - OTHER RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	438,081	182,268	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		438,081	182,268	
	K - DIETARY COSTS TO CAFETERIA				
1.00	CAFETERIA	11.00	107,595	98,690	1.00
	0		107,595	98,690	
	M - REPAIRS AND MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	638,359	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/28/2020 10:36 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
	0		0	638,359	
	N - CASE MANAGEMENT				
1.00	ADMINISTRATIVE AND GENERAL	5.02	280,046	30,636	1.00
2.00	SOCIAL SERVICE	17.00	190,255	19,174	2.00
	0		470,301	49,810	
500.00	Grand Total: Increases		1,902,299	4,777,853	500.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/28/2020 10:36 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	1,325,901	0		1.00
	0		0	1,325,901			
	B - RENT AND LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,850	10		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.02	0	15,815	10		2.00
3.00	OPERATION OF PLANT	7.00	0	13,390	0		3.00
4.00	DIETARY	10.00	0	1,853	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,860	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	20,769	0		6.00
7.00	PHARMACY	15.00	0	59,466	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,012	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	5,249	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,008	0		10.00
11.00	OPERATING ROOM	50.00	0	28,242	0		11.00
12.00	RECOVERY ROOM	51.00	0	1,999	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,303	0		13.00
14.00	MRI	58.00	0	1,792	0		14.00
15.00	LABORATORY	60.00	0	1,008	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	6,071	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	1,008	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	2,838	0		18.00
19.00	CLINIC	90.00	0	3,846	0		19.00
20.00	EMERGENCY	91.00	0	2,783	0		20.00
21.00	AMBULANCE SERVICES	95.00	0	4,508	0		21.00
	0		0	189,670			
	C - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	456,708	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	456,708			
	D - CNO COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	122,423	0	0		1.00
	0		122,423	0			
	E - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,496	0		1.00
2.00	OPERATING ROOM	50.00	0	237,382	0		2.00
	0		0	246,878			
	F - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	889,906	0		1.00
	0		0	889,906			
	G - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	234,238	32,376	0		1.00
	0		234,238	32,376			
	I - MISC DEPARTMENTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	529,661	667,287	0		1.00
	0		529,661	667,287			
	J - OTHER RADIOLOGY						
1.00	ULTRASOUND	54.01	98,243	9,314	0		1.00
2.00	RADIOISOTOPE	56.00	84,515	121,434	0		2.00
3.00	CT SCAN	57.00	169,876	41,414	0		3.00
4.00	MRI	58.00	85,447	10,106	0		4.00
	0		438,081	182,268			
	K - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	107,595	98,690	0		1.00
	0		107,595	98,690			
	M - REPAIRS AND MAINTENANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,377	0		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.02	0	101,942	0		2.00
3.00	HOUSEKEEPING	9.00	0	2,062	0		3.00
4.00	DIETARY	10.00	0	837	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	1,827	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,487	0		6.00
7.00	PHARMACY	15.00	0	24,031	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,631	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	14,957	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	836	0		10.00
11.00	NURSERY	43.00	0	384	0		11.00
12.00	OPERATING ROOM	50.00	0	16,427	0		12.00
13.00	RECOVERY ROOM	51.00	0	1,486	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	120,709	0		14.00
15.00	ULTRASOUND	54.01	0	6,298	0		15.00
16.00	RADIOISOTOPE	56.00	0	27,920	0		16.00
17.00	CT SCAN	57.00	0	108,782	0		17.00

RECLASSIFICATIONS

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/28/2020 10:36 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
18.00	MRI	58.00	0	82,441	0		18.00
19.00	LABORATORY	60.00	0	67,816	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	15,094	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	759	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	2,769	0		22.00
23.00	CLINIC	90.00	0	1,389	0		23.00
24.00	EMERGENCY	91.00	0	4,490	0		24.00
25.00	AMBULANCE SERVICES	95.00	0	22,608	0		25.00
26.00	AMBULANCE SERVICES				0		26.00
	0		0	638,359			
	N - CASE MANAGEMENT						
1.00	NURSING ADMINISTRATION	13.00	470,301	49,810	0		1.00
2.00		0.00	0	0	0		2.00
	0		470,301	49,810			
500.00	Grand Total: Decreases		1,902,299	4,777,853			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I Date/Time Prepared: 8/28/2020 10:36 am

		Beginning Balances	Acquisitions 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	193,225	0	0	0	0	1.00
2.00	Land Improvements	1,015,684	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,299,654	0	0	0	0	3.00
4.00	Building Improvements	33,380,013	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	4,602,668	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	67,491,244	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	67,491,244	0	0	0	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	193,225	0	1.00
2.00	Land Improvements	1,015,684	0	2.00
3.00	Buildings and Fixtures	28,299,654	0	3.00
4.00	Building Improvements	33,380,013	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	4,602,668	0	7.00
8.00	Subtotal (sum of lines 1-7)	67,491,244	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	67,491,244	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 8/28/2020 10:36 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	969,896	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,262,298	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,232,194	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	969,896	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,262,298	2.00
3.00	Total (sum of lines 1-2)	0	3,232,194	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III | Date/Time Prepared: 8/28/2020 10:36 am

	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1,718,591	93,473	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,322,581	168,907	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,041,172	262,380	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,781	80,703	348,261	0	2,247,809	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	841	27,744	0	0	2,520,073	2.00
3.00	Total (sum of lines 1-2)	7,622	108,447	348,261	0	4,767,882	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/28/2020 10:36 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-21,963	ADMINISTRATIVE AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-12,387	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,649,217			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	-175,158			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-52,549	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,317	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-3,585	ADMINISTRATIVE AND GENERAL	5.02	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 - CAP REL COSTS-BLDG & FIXT	A	362,205	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	43,589	CAP REL COSTS-MVBLE EQUIP	2.00	9	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)	A	-4,730	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-14,155	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/28/2020 10:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	FITNESS REVENUE	B	-1,825	ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.02	MISCELLANEOUS INCOME	B	-57,321	ADMINISTRATIVE AND GENERAL	5.02	0	33.02
33.03	PATIENT PHONE DEPRECIATION	A	-2,628	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.03
33.04	CHARITABLE CONTRIBUTIONS	A	-3,899	ADMINISTRATIVE AND GENERAL	5.02	0	33.04
33.05	EMPLOYEE SELF INS DISCOUNTS	B	87,001	ADMINISTRATIVE AND GENERAL	5.02	0	33.05
33.07	POB CAPITAL RELATED EXPENSE	A	386,490	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	POB CAPITAL RELATED EXPENSE	A	19,322	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
35.00	MARKETING EXPENSE	A	-92,229	ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	PENALTIES	A	-571	ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-2,573	ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	COUNTRY CLUB / SOCIAL DUES	A	-520	ADMINISTRATIVE AND GENERAL	5.02	0	38.00
40.00	PHYSICIAN RECRUITING	A	-2,025	ADMINISTRATIVE AND GENERAL	5.02	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,200,045				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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 8/28/2020 10:36 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00		PASI CAPITAL COSTS - BLDG &	0	0	1.00
2.00	0.00		PASI CAPITAL COSTS - MOVEABL	0	0	2.00
3.00	0.00		PASI OPERATING COSTS	0	0	3.00
3.02	0.00		SHARED SERVICE CENTER ALLOCA	0	0	3.02
3.04	0.00		NEW CAPITAL - BUILDING AND F	0	0	3.04
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	6,781	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	841	0	4.01
4.02	5.02	ADMINISTRATIVE AND GENERAL	PASI Operating Costs	190,672	180,635	4.02
4.03	5.02	ADMINISTRATIVE AND GENERAL	Shared Service Center Alloca	665,165	561,729	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	35,001	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	37,709	0	4.05
4.06	5.02	ADMINISTRATIVE AND GENERAL	Non-Capital Home Office Cost	1,066,223	0	4.06
4.07	5.02	ADMINISTRATIVE AND GENERAL	Malpractice Costs	56,012	392,336	4.07
4.08	5.02	ADMINISTRATIVE AND GENERAL	Management Fees	0	443,032	4.08
4.09	5.02	ADMINISTRATIVE AND GENERAL	401K Fees	0	5,558	4.09
4.10	5.02	ADMINISTRATIVE AND GENERAL	Audit Fees	0	22,544	4.10
4.11	5.02	ADMINISTRATIVE AND GENERAL	Corporate Overhead Allocatio	0	475,594	4.11
4.12	5.02	ADMINISTRATIVE AND GENERAL	HIIM Allocation	0	147,157	4.12
4.13	5.02	ADMINISTRATIVE AND GENERAL	PASI Lien Unit Collection Fe	0	4,977	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,058,404	2,233,562	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
				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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	B		0.00	HOSPITAL LAUNDRY SERVICE	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 8/28/2020 10:36 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	0	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
3.02	0	0	3.02
3.04	0	0	3.04
4.00	6,781	11	4.00
4.01	841	11	4.01
4.02	10,037	0	4.02
4.03	103,436	0	4.03
4.04	35,001	10	4.04
4.05	37,709	10	4.05
4.06	1,066,223	0	4.06
4.07	-336,324	0	4.07
4.08	-443,032	0	4.08
4.09	-5,558	0	4.09
4.10	-22,544	0	4.10
4.11	-475,594	0	4.11
4.12	-147,157	0	4.12
4.13	-4,977	0	4.13
5.00	-175,158		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	HOSPITAL MANAGEMENT		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY SERVICE		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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 8/28/2020 10:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	769,994	769,994	0	0	0	1.00
2.00	50.00	OPERATING ROOM	429,902	429,902	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	115,981	115,981	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	1,507	1,507	0	0	0	4.00
5.00	91.00	EMERGENCY	2,076,800	331,833	1,744,967	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			3,394,184	1,649,217	1,744,967		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	769,994		1.00
2.00	50.00	OPERATING ROOM	0	0	0	429,902		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	115,981		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,507		4.00
5.00	91.00	EMERGENCY	0	0	0	331,833		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,649,217		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1318

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

Worksheet A-8-3 Parts I-VI

Date/Time Prepared: 8/28/2020 10:36 am

Physical Therapy | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	5.19	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,333.19	2,496.48	2,936.96	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.04	50.50	17.50	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.52	40.52	25.25			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	270,122	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	126,072	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	396,194	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	51,397	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	447,591	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	447,591	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/28/2020 10:36 am
		Physical Therapy	Cost

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.04	50.50	17.50	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	447,591	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	447,591	63.00
64.00	Total cost of outside supplier services (from your records)	411,470	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/28/2020 10:36 am
		Occupational Therapy	Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	5.19	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,269.90	53.05	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.82	50.50	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.41	38.41	25.25			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	174,374	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	2,679	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	177,053	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	177,053	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	177,053	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/28/2020 10:36 am

Occupational Therapy | Cost

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.82	50.50	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	177,053	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	177,053	63.00
64.00	Total cost of outside supplier services (from your records)	165,072	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/28/2020 10:36 am

Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	5.19	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	914.76	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.84	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.92	36.92	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	67,546	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	67,546	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	67,546	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	67,546	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/28/2020 10:36 am

Speech Pathology | Cost

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.84	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	67,546	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	67,546	63.00
64.00	Total cost of outside supplier services (from your records)	66,133	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,247,809	2,247,809				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,520,073		2,520,073			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,530,719	10,254	11,497	1,552,470		4.00
5.01	00570	ADMITTING	1,196,948	16,521	18,522	62,934	1,294,925	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	6,902,374	138,982	155,816	155,060	0	5.02
7.00	00700	OPERATION OF PLANT	2,462,805	609,408	683,225	34,267	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,037	26,555	29,771	0	0	8.00
9.00	00900	HOUSEKEEPING	484,136	25,636	28,741	42,110	0	9.00
10.00	01000	DIETARY	147,205	32,961	36,953	10,724	0	10.00
11.00	01100	CAFETERIA	153,736	29,601	33,186	12,784	0	11.00
13.00	01300	NURSING ADMINISTRATION	343,701	8,138	9,124	38,289	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	228,704	41,343	46,351	9,599	0	14.00
15.00	01500	PHARMACY	497,666	23,881	26,773	40,171	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	265,017	38,646	43,327	7,445	0	16.00
17.00	01700	SOCIAL SERVICE	209,429	10,045	11,262	22,606	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,185,457	318,726	357,331	216,863	68,231	30.00
31.00	03100	INTENSIVE CARE UNIT	456,670	40,088	44,943	47,696	8,920	31.00
43.00	04300	NURSERY	266,614	8,708	9,763	27,832	2,053	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	784,976	150,945	169,228	55,720	115,412	50.00
51.00	05100	RECOVERY ROOM	298,129	11,882	13,321	31,419	22,722	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,088,139	127,204	142,612	99,622	310,266	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,365,933	35,705	40,029	90,280	175,092	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	81,584	1,372	1,538	0	3,690	62.00
65.00	06500	RESPIRATORY THERAPY	560,688	36,077	40,446	56,918	31,838	65.00
66.00	06600	PHYSICAL THERAPY	420,361	102,940	115,408	58	20,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	166,200	2,802	3,141	0	9,058	67.00
68.00	06800	SPEECH PATHOLOGY	66,133	0	0	0	1,513	68.00
69.00	06900	ELECTROCARDIOLOGY	225,339	47,261	52,986	22,816	49,984	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,660	0	0	0	32,311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,218	0	0	0	12,991	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	889,906	0	0	0	194,568	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	126,023	31,600	35,428	13,171	732	90.00
91.00	09100	EMERGENCY	3,855,574	85,675	96,052	418,445	176,350	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	446,742	29,729	33,330	35,559	59,040	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,794,705	2,042,685	2,290,104	1,552,388	1,294,925	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,138	10,245	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,836	195,986	219,724	82	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,810,541	2,247,809	2,520,073	1,552,470	1,294,925	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	7,352,232	7,352,232				5.02
7.00	00700	OPERATION OF PLANT	3,789,705	1,094,448	4,884,153			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,363	37,359	101,591	268,313		8.00
9.00	00900	HOUSEKEEPING	580,623	167,681	98,077	0	846,381	9.00
10.00	01000	DIETARY	227,843	65,800	126,099	0	23,350	10.00
11.00	01100	CAFETERIA	229,307	66,223	113,245	0	20,970	11.00
13.00	01300	NURSING ADMINISTRATION	399,252	115,302	31,136	0	5,765	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	325,997	94,146	158,169	0	29,289	14.00
15.00	01500	PHARMACY	588,491	169,953	91,361	0	16,918	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	354,435	102,359	147,850	0	27,378	16.00
17.00	01700	SOCIAL SERVICE	253,342	73,164	38,430	0	7,116	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,146,608	908,725	1,219,358	210,745	225,792	30.00
31.00	03100	INTENSIVE CARE UNIT	598,317	172,791	153,365	31,662	28,399	31.00
43.00	04300	NURSERY	314,970	90,962	33,315	25,906	6,169	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,276,281	368,584	577,476	0	106,933	50.00
51.00	05100	RECOVERY ROOM	377,473	109,012	45,458	0	8,418	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,767,843	510,544	486,649	0	90,114	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,707,039	492,984	136,596	0	25,294	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88,184	25,467	5,249	0	972	62.00
65.00	06500	RESPIRATORY THERAPY	725,967	209,656	138,020	0	25,558	65.00
66.00	06600	PHYSICAL THERAPY	658,921	190,293	393,821	0	72,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,201	52,330	10,720	0	1,985	67.00
68.00	06800	SPEECH PATHOLOGY	67,646	19,536	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	398,386	115,052	180,809	0	33,481	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,971	18,475	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	228,209	65,906	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,084,474	313,191	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	206,954	59,767	120,895	0	22,387	90.00
91.00	09100	EMERGENCY	4,632,096	1,337,724	327,769	0	60,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	604,400	174,548	113,734	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,359,530	7,221,982	4,849,192	268,313	839,907	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,383	5,598	34,961	0	6,474	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	431,628	124,652	0	0	0	192.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,810,541	7,352,232	4,884,153	268,313	846,381	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	443,092					10.00
11.00	01100	CAFETERIA	0	429,745				11.00
13.00	01300	NURSING ADMINISTRATION	0	9,292	560,747			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,238	0	614,839		14.00
15.00	01500	PHARMACY	0	13,527	0	15,881	896,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,448	0	296	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,396	11,788	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	390,500	88,781	279,675	33,077	0	30.00
31.00	03100	INTENSIVE CARE UNIT	52,592	14,760	55,578	2,762	0	31.00
43.00	04300	NURSERY	0	9,071	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,176	25,981	84,441	0	50.00
51.00	05100	RECOVERY ROOM	0	9,987	37,852	4,244	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,375	0	44,759	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	51,612	0	990	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	24,581	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	21,397	0	13,417	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32	0	1,683	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	8,692	0	1,302	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,187	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	65,197	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	268,131	896,131	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,626	12,163	2,033	0	90.00
91.00	09100	EMERGENCY	0	92,541	137,710	21,264	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,762	0	21,594	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	443,092	429,713	560,747	614,839	896,131	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	443,092	429,745	560,747	614,839	896,131	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	638,766					16.00
17.00	01700	SOCIAL SERVICE	0	391,236				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	203,114	307,294	7,013,669	0	7,013,669	30.00
31.00	03100	INTENSIVE CARE UNIT	113	46,168	1,156,507	0	1,156,507	31.00
43.00	04300	NURSERY	7,092	37,774	525,259	0	525,259	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	147,032	0	2,607,904	0	2,607,904	50.00
51.00	05100	RECOVERY ROOM	113	0	592,557	0	592,557	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,813	0	3,021,097	0	3,021,097	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,402	0	2,417,917	0	2,417,917	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	72	0	144,525	0	144,525	62.00
65.00	06500	RESPIRATORY THERAPY	113	0	1,134,128	0	1,134,128	65.00
66.00	06600	PHYSICAL THERAPY	78,306	0	1,395,981	0	1,395,981	66.00
67.00	06700	OCCUPATIONAL THERAPY	113	0	246,349	0	246,349	67.00
68.00	06800	SPEECH PATHOLOGY	113	0	87,295	0	87,295	68.00
69.00	06900	ELECTROCARDIOLOGY	1,000	0	738,722	0	738,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	91,633	0	91,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	359,312	0	359,312	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,561,927	0	2,561,927	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,518	0	432,343	0	432,343	90.00
91.00	09100	EMERGENCY	98,689	0	6,708,487	0	6,708,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	20,163	0	952,201	0	952,201	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	638,766	391,236	32,187,813	0	32,187,813	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	66,416	0	66,416	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	556,312	0	556,312	192.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	638,766	391,236	32,810,541	0	32,810,541	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,254	11,497	21,751	21,751	4.00
5.01	00570	ADMITTING	0	16,521	18,522	35,043	882	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	138,982	155,816	294,798	2,173	5.02
7.00	00700	OPERATION OF PLANT	0	609,408	683,225	1,292,633	480	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,555	29,771	56,326	0	8.00
9.00	00900	HOUSEKEEPING	0	25,636	28,741	54,377	590	9.00
10.00	01000	DIETARY	0	32,961	36,953	69,914	150	10.00
11.00	01100	CAFETERIA	0	29,601	33,186	62,787	179	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,138	9,124	17,262	537	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	41,343	46,351	87,694	135	14.00
15.00	01500	PHARMACY	0	23,881	26,773	50,654	563	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,646	43,327	81,973	104	16.00
17.00	01700	SOCIAL SERVICE	0	10,045	11,262	21,307	317	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	318,726	357,331	676,057	3,039	30.00
31.00	03100	INTENSIVE CARE UNIT	0	40,088	44,943	85,031	668	31.00
43.00	04300	NURSERY	0	8,708	9,763	18,471	390	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	150,945	169,228	320,173	781	50.00
51.00	05100	RECOVERY ROOM	0	11,882	13,321	25,203	440	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	127,204	142,612	269,816	1,396	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	35,705	40,029	75,734	1,265	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,372	1,538	2,910	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	36,077	40,446	76,523	798	65.00
66.00	06600	PHYSICAL THERAPY	0	102,940	115,408	218,348	1	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,802	3,141	5,943	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,261	52,986	100,247	320	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	31,600	35,428	67,028	185	90.00
91.00	09100	EMERGENCY	0	85,675	96,052	181,727	5,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	29,729	33,330	63,059	498	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,042,685	2,290,104	4,332,789	21,750	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,138	10,245	19,383	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	195,986	219,724	415,710	1	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,247,809	2,520,073	4,767,882	21,751	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	ADMITTING	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	35,925					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	296,971				5.02
7.00	00700	OPERATION OF PLANT	0	44,207	1,337,320			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,509	27,816	85,651		8.00
9.00	00900	HOUSEKEEPING	0	6,773	26,854	0	88,594	9.00
10.00	01000	DIETARY	0	2,658	34,527	0	2,444	10.00
11.00	01100	CAFETERIA	0	2,675	31,007	0	2,195	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,657	8,525	0	603	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,803	43,308	0	3,066	14.00
15.00	01500	PHARMACY	0	6,865	25,015	0	1,771	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,134	40,482	0	2,866	16.00
17.00	01700	SOCIAL SERVICE	0	2,955	10,523	0	745	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,897	36,705	333,870	67,274	23,633	30.00
31.00	03100	INTENSIVE CARE UNIT	248	6,979	41,993	10,107	2,973	31.00
43.00	04300	NURSERY	57	3,674	9,122	8,270	646	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,208	14,888	158,118	0	11,193	50.00
51.00	05100	RECOVERY ROOM	632	4,403	12,447	0	881	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,555	20,622	133,249	0	9,433	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,867	19,913	37,401	0	2,648	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	103	1,029	1,437	0	102	62.00
65.00	06500	RESPIRATORY THERAPY	885	8,468	37,791	0	2,675	65.00
66.00	06600	PHYSICAL THERAPY	560	7,686	107,831	0	7,633	66.00
67.00	06700	OCCUPATIONAL THERAPY	252	2,114	2,935	0	208	67.00
68.00	06800	SPEECH PATHOLOGY	42	789	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,389	4,647	49,507	0	3,505	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	898	746	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	361	2,662	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,408	12,650	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20	2,414	33,102	0	2,343	90.00
91.00	09100	EMERGENCY	4,902	54,035	89,746	0	6,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,641	7,050	31,141	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,925	291,710	1,327,747	85,651	87,916	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	226	9,573	0	678	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,035	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,925	296,971	1,337,320	85,651	88,594	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	109,693					10.00
11.00	01100	CAFETERIA	0	98,843				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,137	33,721			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,665	0	139,671		14.00
15.00	01500	PHARMACY	0	3,111	0	3,608	91,587	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,483	0	67	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,701	709	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,673	20,420	16,820	7,514	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,020	3,395	3,342	628	0	31.00
43.00	04300	NURSERY	0	2,086	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,871	1,562	19,182	0	50.00
51.00	05100	RECOVERY ROOM	0	2,297	2,276	964	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,206	0	10,168	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	11,871	0	225	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	5,584	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	4,921	0	3,048	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7	0	382	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	1,999	0	296	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,087	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,811	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	60,910	91,587	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,294	731	462	0	90.00
91.00	09100	EMERGENCY	0	21,287	8,281	4,830	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,085	0	4,905	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,693	98,836	33,721	139,671	91,587	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	109,693	98,843	33,721	139,671	91,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,109					16.00
17.00	01700	SOCIAL SERVICE	0	38,257				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,690	30,048	1,355,640	0	1,355,640	30.00
31.00	03100	INTENSIVE CARE UNIT	23	4,515	172,922	0	172,922	31.00
43.00	04300	NURSERY	1,456	3,694	47,866	0	47,866	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,179	0	564,155	0	564,155	50.00
51.00	05100	RECOVERY ROOM	23	0	49,566	0	49,566	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,766	0	479,211	0	479,211	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	698	0	154,622	0	154,622	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	15	0	11,180	0	11,180	62.00
65.00	06500	RESPIRATORY THERAPY	23	0	135,132	0	135,132	65.00
66.00	06600	PHYSICAL THERAPY	16,073	0	358,521	0	358,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	23	0	11,475	0	11,475	67.00
68.00	06800	SPEECH PATHOLOGY	23	0	854	0	854	68.00
69.00	06900	ELECTROCARDIOLOGY	205	0	162,115	0	162,115	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,731	0	3,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,834	0	17,834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	170,555	0	170,555	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	517	0	108,096	0	108,096	90.00
91.00	09100	EMERGENCY	20,256	0	397,276	0	397,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,139	0	116,518	0	116,518	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,109	38,257	4,317,269	0	4,317,269	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	29,860	0	29,860	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	420,753	0	420,753	192.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	131,109	38,257	4,767,882	0	4,767,882	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	193,337					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		193,337				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	882	882	13,065,723			4.00
5.01	00570	ADMITTING	1,421	1,421	529,661	176,436,192		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	11,954	11,954	1,305,002	0	-7,352,232	5.02
7.00	00700	OPERATION OF PLANT	52,416	52,416	288,393	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,284	2,284	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,205	2,205	354,405	0	0	9.00
10.00	01000	DIETARY	2,835	2,835	90,254	0	0	10.00
11.00	01100	CAFETERIA	2,546	2,546	107,595	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	700	700	322,247	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,556	3,556	80,789	0	0	14.00
15.00	01500	PHARMACY	2,054	2,054	338,082	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,324	3,324	62,659	0	0	16.00
17.00	01700	SOCIAL SERVICE	864	864	190,255	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,414	27,414	1,825,135	9,297,091	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,448	3,448	401,416	1,215,408	0	31.00
43.00	04300	NURSERY	749	749	234,238	279,672	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,983	12,983	468,943	15,725,867	0	50.00
51.00	05100	RECOVERY ROOM	1,022	1,022	264,429	3,096,066	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,941	10,941	838,428	42,268,189	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,071	3,071	759,802	23,857,722	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	118	118	0	502,735	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,103	3,103	479,029	4,338,165	0	65.00
66.00	06600	PHYSICAL THERAPY	8,854	8,854	486	2,746,184	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	241	241	0	1,234,183	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	206,144	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,065	4,065	192,024	6,810,792	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,402,640	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,770,180	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,511,543	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,718	2,718	110,848	99,791	0	90.00
91.00	09100	EMERGENCY	7,369	7,369	3,521,646	24,029,172	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,557	2,557	299,265	8,044,648	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,694	175,694	13,065,031	176,436,192	-7,352,232	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	786	786	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,857	16,857	692	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,247,809	2,520,073	1,552,470	1,294,925		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.626378	13.034613	0.118820	0.007339		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			21,751	35,925		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001665	0.000204		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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	25,458,309					5.02
7.00	00700	OPERATION OF PLANT	3,789,705	109,807				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,363	2,284	3,449			8.00
9.00	00900	HOUSEKEEPING	580,623	2,205	0	102,761		9.00
10.00	01000	DIETARY	227,843	2,835	0	2,835	3,429	10.00
11.00	01100	CAFETERIA	229,307	2,546	0	2,546	0	11.00
13.00	01300	NURSING ADMINISTRATION	399,252	700	0	700	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	325,997	3,556	0	3,556	0	14.00
15.00	01500	PHARMACY	588,491	2,054	0	2,054	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	354,435	3,324	0	3,324	0	16.00
17.00	01700	SOCIAL SERVICE	253,342	864	0	864	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,146,608	27,414	2,709	27,414	3,022	30.00
31.00	03100	INTENSIVE CARE UNIT	598,317	3,448	407	3,448	407	31.00
43.00	04300	NURSERY	314,970	749	333	749	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,276,281	12,983	0	12,983	0	50.00
51.00	05100	RECOVERY ROOM	377,473	1,022	0	1,022	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,767,843	10,941	0	10,941	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,707,039	3,071	0	3,071	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88,184	118	0	118	0	62.00
65.00	06500	RESPIRATORY THERAPY	725,967	3,103	0	3,103	0	65.00
66.00	06600	PHYSICAL THERAPY	658,921	8,854	0	8,854	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,201	241	0	241	0	67.00
68.00	06800	SPEECH PATHOLOGY	67,646	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	398,386	4,065	0	4,065	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,971	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	228,209	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,084,474	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	206,954	2,718	0	2,718	0	90.00
91.00	09100	EMERGENCY	4,632,096	7,369	0	7,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	604,400	2,557	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,007,298	109,021	3,449	101,975	3,429	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,383	786	0	786	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	431,628	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,352,232	4,884,153	268,313	846,381	443,092	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.288795	44.479432	77.794433	8.236403	129.219014	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	296,971	1,337,320	85,651	88,594	109,693	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011665	12.178823	24.833575	0.862136	31.989793	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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	13,597					11.00
13.00	01300	NURSING ADMINISTRATION	294	3,894,644				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	229	0	2,040,614			14.00
15.00	01500	PHARMACY	428	0	52,709	942,615		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	204	0	982	0	1,468,665	16.00
17.00	01700	SOCIAL SERVICE	234	81,873	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,809	1,942,474	109,781	0	467,007	30.00
31.00	03100	INTENSIVE CARE UNIT	467	386,015	9,168	0	260	31.00
43.00	04300	NURSERY	287	0	0	0	16,306	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	670	180,448	280,254	0	338,058	50.00
51.00	05100	RECOVERY ROOM	316	262,902	14,087	0	260	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,404	0	148,551	0	176,609	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,633	0	3,286	0	7,823	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	81,584	0	165	62.00
65.00	06500	RESPIRATORY THERAPY	677	0	44,531	0	260	65.00
66.00	06600	PHYSICAL THERAPY	1	0	5,585	0	180,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	260	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	260	68.00
69.00	06900	ELECTROCARDIOLOGY	275	0	4,322	0	2,299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	30,492	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	216,386	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	889,906	942,615	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	178	84,476	6,749	0	5,789	90.00
91.00	09100	EMERGENCY	2,928	956,456	70,573	0	226,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	562	0	71,668	0	46,359	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,596	3,894,644	2,040,614	942,615	1,468,665	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	429,745	560,747	614,839	896,131	638,766	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.605869	0.143979	0.301301	0.950686	0.434930	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,843	33,721	139,671	91,587	131,109	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.269471	0.008658	0.068446	0.097163	0.089271	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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:36 am

		Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			17.00	
	GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	3,449	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,709	30.00
31.00	03100	INTENSIVE CARE UNIT	407	31.00
43.00	04300	NURSERY	333	43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03610	SLEEP LAB	0	76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	95.00
	SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,449	118.00
	NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	391,236	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	113.434619	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,257	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.092201	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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,013,669		7,013,669	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,156,507		1,156,507	0	0	31.00
43.00	04300	NURSERY	525,259		525,259	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,607,904		2,607,904	0	0	50.00
51.00	05100	RECOVERY ROOM	592,557		592,557	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,021,097		3,021,097	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,417,917		2,417,917	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,525		144,525	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,134,128	0	1,134,128	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,395,981	0	1,395,981	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	246,349	0	246,349	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	87,295	0	87,295	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	738,722		738,722	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,633		91,633	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	359,312		359,312	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,561,927		2,561,927	0	0	73.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	432,343		432,343	0	0	90.00
91.00	09100	EMERGENCY	6,708,487		6,708,487	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,750,350		1,750,350		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	952,201		952,201	0	0	95.00
200.00		Subtotal (see instructions)	33,938,163	0	33,938,163	0	0	200.00
201.00		Less Observation Beds	1,750,350		1,750,350		0	201.00
202.00		Total (see instructions)	32,187,813	0	32,187,813	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,281,746		6,281,746			30.00
31.00	03100	INTENSIVE CARE UNIT	1,215,408		1,215,408			31.00
43.00	04300	NURSERY	279,672		279,672			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,750,542	11,975,325	15,725,867	0.165835	0.000000	50.00
51.00	05100	RECOVERY ROOM	630,374	2,465,692	3,096,066	0.191390	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,559,551	35,708,638	42,268,189	0.071474	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	5,890,532	17,967,190	23,857,722	0.101347	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	269,536	233,199	502,735	0.287477	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	3,326,268	1,011,897	4,338,165	0.261430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	618,040	2,128,144	2,746,184	0.508335	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	553,850	680,333	1,234,183	0.199605	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	102,216	103,928	206,144	0.423466	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,692,000	5,118,792	6,810,792	0.108463	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,700,730	2,701,910	4,402,640	0.020813	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,137,799	632,381	1,770,180	0.202980	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,391,707	15,119,836	26,511,543	0.096634	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	39,458	60,333	99,791	4.332485	0.000000	90.00
91.00	09100	EMERGENCY	2,573,685	21,455,487	24,029,172	0.279181	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	636,416	2,378,929	3,015,345	0.580481	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,044,648	8,044,648	0.118365	0.000000	95.00
200.00		Subtotal (see instructions)	48,649,530	127,786,662	176,436,192			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	48,649,530	127,786,662	176,436,192			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
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 PATIENT	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
76.00	03610	SLEEP LAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,013,669		7,013,669	0	7,013,669	30.00
31.00	03100	INTENSIVE CARE UNIT	1,156,507		1,156,507	0	1,156,507	31.00
43.00	04300	NURSERY	525,259		525,259	0	525,259	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,607,904		2,607,904	0	2,607,904	50.00
51.00	05100	RECOVERY ROOM	592,557		592,557	0	592,557	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,021,097		3,021,097	0	3,021,097	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,417,917		2,417,917	0	2,417,917	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,525		144,525	0	144,525	62.00
65.00	06500	RESPIRATORY THERAPY	1,134,128	0	1,134,128	0	1,134,128	65.00
66.00	06600	PHYSICAL THERAPY	1,395,981	0	1,395,981	0	1,395,981	66.00
67.00	06700	OCCUPATIONAL THERAPY	246,349	0	246,349	0	246,349	67.00
68.00	06800	SPEECH PATHOLOGY	87,295	0	87,295	0	87,295	68.00
69.00	06900	ELECTROCARDIOLOGY	738,722		738,722	0	738,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,633		91,633	0	91,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	359,312		359,312	0	359,312	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,561,927		2,561,927	0	2,561,927	73.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	432,343		432,343	0	432,343	90.00
91.00	09100	EMERGENCY	6,708,487		6,708,487	0	6,708,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,750,350		1,750,350		1,750,350	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	952,201		952,201	0	952,201	95.00
200.00		Subtotal (see instructions)	33,938,163	0	33,938,163	0	33,938,163	200.00
201.00		Less Observation Beds	1,750,350		1,750,350		1,750,350	201.00
202.00		Total (see instructions)	32,187,813	0	32,187,813	0	32,187,813	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,281,746		6,281,746			30.00
31.00	03100	INTENSIVE CARE UNIT	1,215,408		1,215,408			31.00
43.00	04300	NURSERY	279,672		279,672			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,750,542	11,975,325	15,725,867	0.165835	0.000000	50.00
51.00	05100	RECOVERY ROOM	630,374	2,465,692	3,096,066	0.191390	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,559,551	35,708,638	42,268,189	0.071474	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	5,890,532	17,967,190	23,857,722	0.101347	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	269,536	233,199	502,735	0.287477	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	3,326,268	1,011,897	4,338,165	0.261430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	618,040	2,128,144	2,746,184	0.508335	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	553,850	680,333	1,234,183	0.199605	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	102,216	103,928	206,144	0.423466	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,692,000	5,118,792	6,810,792	0.108463	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,700,730	2,701,910	4,402,640	0.020813	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,137,799	632,381	1,770,180	0.202980	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,391,707	15,119,836	26,511,543	0.096634	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	39,458	60,333	99,791	4.332485	0.000000	90.00
91.00	09100	EMERGENCY	2,573,685	21,455,487	24,029,172	0.279181	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	636,416	2,378,929	3,015,345	0.580481	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,044,648	8,044,648	0.118365	0.000000	95.00
200.00		Subtotal (see instructions)	48,649,530	127,786,662	176,436,192			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	48,649,530	127,786,662	176,436,192			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.165835	50.00
51.00	05100	RECOVERY ROOM	0.191390	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071474	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.101347	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287477	62.00
65.00	06500	RESPIRATORY THERAPY	0.261430	65.00
66.00	06600	PHYSICAL THERAPY	0.508335	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.199605	67.00
68.00	06800	SPEECH PATHOLOGY	0.423466	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108463	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.020813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096634	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	4.332485	90.00
91.00	09100	EMERGENCY	0.279181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580481	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.118365	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,607,904	564,155	2,043,749	0	0	50.00
51.00	05100	RECOVERY ROOM	592,557	49,566	542,991	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,021,097	479,211	2,541,886	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,417,917	154,622	2,263,295	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,525	11,180	133,345	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,134,128	135,132	998,996	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,395,981	358,521	1,037,460	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	246,349	11,475	234,874	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	87,295	854	86,441	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	738,722	162,115	576,607	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,633	3,731	87,902	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	359,312	17,834	341,478	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,561,927	170,555	2,391,372	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	432,343	108,096	324,247	0	0	90.00
91.00	09100	EMERGENCY	6,708,487	397,276	6,311,211	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,750,350	338,316	1,412,034	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	952,201	116,518	835,683	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	25,242,728	3,079,157	22,163,571	0	0	200.00
201.00		Less Observation Beds	1,750,350	338,316	1,412,034	0	0	201.00
202.00		Total (line 200 minus line 201)	23,492,378	2,740,841	20,751,537	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,607,904	15,725,867	0.165835	50.00
51.00	05100	RECOVERY ROOM	592,557	3,096,066	0.191390	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,021,097	42,268,189	0.071474	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	2,417,917	23,857,722	0.101347	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	144,525	502,735	0.287477	62.00
65.00	06500	RESPIRATORY THERAPY	1,134,128	4,338,165	0.261430	65.00
66.00	06600	PHYSICAL THERAPY	1,395,981	2,746,184	0.508335	66.00
67.00	06700	OCCUPATIONAL THERAPY	246,349	1,234,183	0.199605	67.00
68.00	06800	SPEECH PATHOLOGY	87,295	206,144	0.423466	68.00
69.00	06900	ELECTROCARDIOLOGY	738,722	6,810,792	0.108463	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,633	4,402,640	0.020813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	359,312	1,770,180	0.202980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,561,927	26,511,543	0.096634	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	432,343	99,791	4.332485	90.00
91.00	09100	EMERGENCY	6,708,487	24,029,172	0.279181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,750,350	3,015,345	0.580481	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	952,201	8,044,648	0.118365	95.00
200.00		Subtotal (sum of lines 50 thru 199)	25,242,728	168,659,366		200.00
201.00		Less Observation Beds	1,750,350	0		201.00
202.00		Total (line 200 minus line 201)	23,492,378	168,659,366		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	564,155	15,725,867	0.035874	1,079,957	38,742	50.00
51.00	05100	RECOVERY ROOM	49,566	3,096,066	0.016009	164,447	2,633	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	479,211	42,268,189	0.011337	3,344,741	37,919	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	154,622	23,857,722	0.006481	2,823,771	18,301	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,180	502,735	0.022238	152,821	3,398	62.00
65.00	06500	RESPIRATORY THERAPY	135,132	4,338,165	0.031150	1,653,366	51,502	65.00
66.00	06600	PHYSICAL THERAPY	358,521	2,746,184	0.130552	326,209	42,587	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,475	1,234,183	0.009298	298,259	2,773	67.00
68.00	06800	SPEECH PATHOLOGY	854	206,144	0.004143	41,239	171	68.00
69.00	06900	ELECTROCARDIOLOGY	162,115	6,810,792	0.023803	929,406	22,123	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,731	4,402,640	0.000847	727,066	616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,834	1,770,180	0.010075	342,010	3,446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,555	26,511,543	0.006433	5,519,943	35,510	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	108,096	99,791	1.083224	0	0	90.00
91.00	09100	EMERGENCY	397,276	24,029,172	0.016533	1,227,243	20,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	338,316	3,015,345	0.112198	255,148	28,627	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,962,639	160,614,718		18,885,626	308,638	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
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 PATIENT	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
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,725,867	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,096,066	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,268,189	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,857,722	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	502,735	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,338,165	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,746,184	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,234,183	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	206,144	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,810,792	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,402,640	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,770,180	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,511,543	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	99,791	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,029,172	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,015,345	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	160,614,718		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,079,957	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	164,447	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,344,741	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	2,823,771	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	152,821	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,653,366	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	326,209	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	298,259	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	41,239	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	929,406	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	727,066	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	342,010	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,519,943	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,227,243	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	255,148	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		18,885,626	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.165835	0	2,306,543	0	0	50.00
51.00	05100	RECOVERY ROOM	0.191390	0	513,737	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071474	0	11,103,189	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.101347	0	4,698,970	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287477	0	124,109	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.261430	0	322,198	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.508335	0	470,968	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.199605	0	28,034	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.423466	0	9,793	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108463	0	1,451,308	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.020813	0	267,021	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202980	0	140,816	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096634	0	5,139,411	15,241	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4.332485	0	10,573	5,060	0	90.00
91.00	09100	EMERGENCY	0.279181	0	4,567,711	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580481	0	756,443	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.118365		0			95.00
200.00		Subtotal (see instructions)		0	31,910,824	20,301	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	31,910,824	20,301	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	382,506	0	50.00
51.00	05100	RECOVERY ROOM	98,324	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	793,589	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	476,227	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	35,678	0	62.00
65.00	06500	RESPIRATORY THERAPY	84,232	0	65.00
66.00	06600	PHYSICAL THERAPY	239,410	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,596	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,147	0	68.00
69.00	06900	ELECTROCARDIOLOGY	157,413	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,558	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,583	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	496,642	1,473	73.00
76.00	03610	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	45,807	21,922	90.00
91.00	09100	EMERGENCY	1,275,218	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	439,101	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,568,031	23,395	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,568,031	23,395	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.165835	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.191390	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071474	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.101347	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287477	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.261430	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.508335	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.199605	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.423466	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108463	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.020813	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202980	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096634	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4.332485	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.279181	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580481	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.118365		0			95.00
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: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
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 PATIENT	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
76.00	03610	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,355,640	100,819	1,254,821	3,709	338.32	30.00
31.00	INTENSIVE CARE UNIT	172,922		172,922	407	424.87	31.00
43.00	NURSERY	47,866		47,866	333	143.74	43.00
200.00	Total (lines 30 through 199)	1,576,428		1,475,609	4,449		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	53	17,931	30.00
31.00	INTENSIVE CARE UNIT	11	4,674	31.00
43.00	NURSERY	37	5,318	43.00
200.00	Total (lines 30 through 199)	101	27,923	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II | Date/Time Prepared: 8/28/2020 10:36 am

			Title XIX		Hospital	PPS	
		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	564,155	15,725,867	0.035874	100,822	3,617	50.00
51.00	05100	RECOVERY ROOM	49,566	3,096,066	0.016009	17,713	284	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	479,211	42,268,189	0.011337	124,910	1,416	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	154,622	23,857,722	0.006481	159,355	1,033	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,180	502,735	0.022238	3,128	70	62.00
65.00	06500	RESPIRATORY THERAPY	135,132	4,338,165	0.031150	49,980	1,557	65.00
66.00	06600	PHYSICAL THERAPY	358,521	2,746,184	0.130552	4,056	530	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,475	1,234,183	0.009298	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	854	206,144	0.004143	470	2	68.00
69.00	06900	ELECTROCARDIOLOGY	162,115	6,810,792	0.023803	41,964	999	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,731	4,402,640	0.000847	38,355	32	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,834	1,770,180	0.010075	1,772	18	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,555	26,511,543	0.006433	290,252	1,867	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	108,096	99,791	1.083224	3,123	3,383	90.00
91.00	09100	EMERGENCY	397,276	24,029,172	0.016533	47,605	787	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	338,316	3,015,345	0.112198	7,445	835	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,962,639	160,614,718		890,950	16,430	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318

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

Worksheet D Part III

Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,709	0.00	53	30.00
31.00	03100	INTENSIVE CARE UNIT		0	407	0.00	11	31.00
43.00	04300	NURSERY		0	333	0.00	37	43.00
200.00		Total (lines 30 through 199)		0	4,449		101	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318

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

Worksheet D Part IV
Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
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 PATIENT	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
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,725,867	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,096,066	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,268,189	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,857,722	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	502,735	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,338,165	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,746,184	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,234,183	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	206,144	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,810,792	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,402,640	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,770,180	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,511,543	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	99,791	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,029,172	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,015,345	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	160,614,718		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	100,822	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	17,713	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	124,910	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	159,355	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	3,128	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	49,980	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,056	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	470	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	41,964	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	38,355	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,772	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	290,252	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	3,123	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	47,605	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	7,445	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		890,950	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.165835	0	0	366,882	0	50.00
51.00	05100	RECOVERY ROOM	0.191390	0	0	73,756	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071474	0	0	1,022,664	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.101347	0	0	712,105	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287477	0	0	5,403	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.261430	0	0	16,254	0	65.00
66.00	06600	PHYSICAL THERAPY	0.508335	0	0	24,588	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.199605	0	0	61,173	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.423466	0	0	2,801	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108463	0	0	139,396	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.020813	0	0	78,725	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202980	0	0	2,430	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096634	0	0	462,667	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4.332485	0	0	745	0	90.00
91.00	09100	EMERGENCY	0.279181	0	0	1,233,739	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580481	0	0	120,055	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.118365	0	0			95.00
200.00		Subtotal (see instructions)		0	0	4,323,383	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	4,323,383	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	60,842	50.00
51.00	05100	RECOVERY ROOM	0	14,116	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,094	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	72,170	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,553	62.00
65.00	06500	RESPIRATORY THERAPY	0	4,249	65.00
66.00	06600	PHYSICAL THERAPY	0	12,499	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,210	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,186	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,119	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	493	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,709	73.00
76.00	03610	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	3,228	90.00
91.00	09100	EMERGENCY	0	344,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	69,690	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	731,233	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	731,233	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:36 am

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)	4,014	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,709	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,709	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	298	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	7	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,383	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)	281	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,013,669	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	521,604	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,492,065	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,492,065	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)	1,750.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,420,734	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,420,734	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,156,507	407	2,841.54	221	627,980	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,664,309	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,713,023	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)	491,848	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)	491,848	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)	1,000	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,750.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,750,350	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,355,640	7,013,669	0.193285	1,750,350	338,316	90.00
91.00	Nursing School cost	0	7,013,669	0.000000	1,750,350	0	91.00
92.00	Allied health cost	0	7,013,669	0.000000	1,750,350	0	92.00
93.00	All other Medical Education	0	7,013,669	0.000000	1,750,350	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,014	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,709	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,709	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	298	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	7	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)	53	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)	333	15.00
16.00	Nursery days (title V or XIX only)	37	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,013,669	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	521,604	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,492,065	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,492,065	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)	1,750.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	92,769	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)	92,769	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	525,259	333	1,577.35	37	58,362	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,156,507	407	2,841.54	11	31,257	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)	126,314	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	308,702	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)	27,923	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	16,430	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	44,353	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	264,349	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)	1,000	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,750.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,750,350	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,355,640	7,013,669	0.193285	1,750,350	338,316	90.00
91.00	Nursing School cost	0	7,013,669	0.000000	1,750,350	0	91.00
92.00	Allied health cost	0	7,013,669	0.000000	1,750,350	0	92.00
93.00	All other Medical Education	0	7,013,669	0.000000	1,750,350	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,674,013		30.00
31.00	03100	INTENSIVE CARE UNIT		645,759		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.165835	1,079,957	179,095	50.00
51.00	05100	RECOVERY ROOM	0.191390	164,447	31,474	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071474	3,344,741	239,062	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.101347	2,823,771	286,181	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287477	152,821	43,933	62.00
65.00	06500	RESPIRATORY THERAPY	0.261430	1,653,366	432,239	65.00
66.00	06600	PHYSICAL THERAPY	0.508335	326,209	165,823	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.199605	298,259	59,534	67.00
68.00	06800	SPEECH PATHOLOGY	0.423466	41,239	17,463	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108463	929,406	100,806	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.020813	727,066	15,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202980	342,010	69,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096634	5,519,943	533,414	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4.332485	0	0	90.00
91.00	09100	EMERGENCY	0.279181	1,227,243	342,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580481	255,148	148,109	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,885,626	2,664,309	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)		18,885,626		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3
Component CCN: 15-Z318 | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.165835	8,141	1,350	50.00
51.00	05100	RECOVERY ROOM	0.191390	2,432	465	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071474	31,255	2,234	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.101347	97,180	9,849	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287477	9,100	2,616	62.00
65.00	06500	RESPIRATORY THERAPY	0.261430	301,440	78,805	65.00
66.00	06600	PHYSICAL THERAPY	0.508335	125,666	63,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.199605	109,542	21,865	67.00
68.00	06800	SPEECH PATHOLOGY	0.423466	2,411	1,021	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108463	1,532	166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.020813	78,144	1,626	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202980	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096634	309,467	29,905	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4.332485	0	0	90.00
91.00	09100	EMERGENCY	0.279181	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580481	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,076,310	213,782	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)		1,076,310		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/28/2020 10:36 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		162,805		30.00
31.00	03100	INTENSIVE CARE UNIT		43,845		31.00
43.00	04300	NURSERY		31,220		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.165835	100,822	16,720	50.00
51.00	05100	RECOVERY ROOM	0.191390	17,713	3,390	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071474	124,910	8,928	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.101347	159,355	16,150	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287477	3,128	899	62.00
65.00	06500	RESPIRATORY THERAPY	0.261430	49,980	13,066	65.00
66.00	06600	PHYSICAL THERAPY	0.508335	4,056	2,062	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.199605	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.423466	470	199	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108463	41,964	4,552	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.020813	38,355	798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202980	1,772	360	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096634	290,252	28,048	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4.332485	3,123	13,530	90.00
91.00	09100	EMERGENCY	0.279181	47,605	13,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580481	7,445	4,322	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		890,950	126,314	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)		890,950		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part B Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,591,426	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	6,385,400	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,591,426	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,637,340	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	6,385,400	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	36,608	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,452,464	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)	-851,732	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)	-851,732	30.00
31.00	Primary payer payments	405	31.00
32.00	Subtotal (line 30 minus line 31)	-852,137	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)	1,115,358	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	724,983	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	833,710	36.00
37.00	Subtotal (see instructions)	-127,154	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)	-127,154	40.00
40.01	Sequestration adjustment (see instructions)	0	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	877,452	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)	-1,004,606	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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,288,484		877,452	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	07/25/2019	565,900		0	3.01
3.02		12/20/2019	175,500		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)		741,400		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)		5,029,884		877,452	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		249,115		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,004,606	6.02
7.00	Total Medicare program liability (see instructions)		5,278,999		-127,154	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: 15-1318 Component CCN: 15-Z318	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Prepared: 8/28/2020 10:36 am
	Title XVIII	Swing Beds - SNF	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		650,277		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)		650,277		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		40,637		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		690,914		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: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/28/2020 10:36 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 8/28/2020 10:36 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	496,766	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)	215,920	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	281	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)	712,686	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	712,686	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)	712,686	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,672	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	705,014	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)	705,014	0	19.00
19.01	Sequestration adjustment (see instructions)	14,100	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	650,277	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)	40,637	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	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 8/28/2020 10:36 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,713,023	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)	5,713,023	4.00
5.00	Primary payer payments	13,792	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,756,361	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)	5,756,361	19.00
20.00	Deductibles (exclude professional component)	428,176	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,328,185	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,328,185	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	90,076	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	58,549	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,248	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,386,734	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)	5,386,734	30.00
30.01	Sequestration adjustment (see instructions)	107,735	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	5,029,884	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)	249,115	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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII Date/Time Prepared: 8/28/2020 10:36 am

		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			731,233	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	731,233	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	731,233	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		237,870		8.00
9.00	Ancillary service charges		890,950	4,323,383	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,128,820	4,323,383	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,128,820	4,323,383	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,128,820	3,592,150	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	731,233	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	731,233	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	731,233	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	731,233	36.00
37.00	OTHER ADJUSTMENTS - PAYMENT		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	731,233	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	731,233	40.00
41.00	Interim payments		0	731,233	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 8/28/2020 10:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-113,654	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	20,224,624	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,284,997	0	0	0	6.00
7.00	Inventory	872,192	0	0	0	7.00
8.00	Prepaid expenses	507,378	0	0	0	8.00
9.00	Other current assets	-218,626	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)	14,986,917	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	223,845	0	0	0	13.00
14.00	Accumulated depreciation	-135,093	0	0	0	14.00
15.00	Buildings	10,565,163	0	0	0	15.00
16.00	Accumulated depreciation	-3,796,915	0	0	0	16.00
17.00	Leasehold improvements	10,326,930	0	0	0	17.00
18.00	Accumulated depreciation	-3,835,139	0	0	0	18.00
19.00	Fixed equipment	3,203,321	0	0	0	19.00
20.00	Accumulated depreciation	-1,441,095	0	0	0	20.00
21.00	Automobiles and trucks	583,590	0	0	0	21.00
22.00	Accumulated depreciation	-533,272	0	0	0	22.00
23.00	Major movable equipment	7,632,904	0	0	0	23.00
24.00	Accumulated depreciation	-6,418,161	0	0	0	24.00
25.00	Minor equipment depreciable	4,743,858	0	0	0	25.00
26.00	Accumulated depreciation	-2,920,816	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)	18,699,120	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	11,362,663	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,362,663	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,048,700	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,012,003	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,185,276	0	0	0	38.00
39.00	Payroll taxes payable	-9,622	0	0	0	39.00
40.00	Notes and loans payable (short term)	150,172	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	-10,177,873	0	0	0	43.00
44.00	Other current liabilities	322,532	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-7,517,512	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	281,074	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)	281,074	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-7,236,438	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	52,285,138				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)	52,285,138	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,048,700	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 Date/Time Prepared: 8/28/2020 10:36 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		56,584,135		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,298,997				2.00
3.00	Total (sum of line 1 and line 2)		52,285,138		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)		52,285,138		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)		52,285,138		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: 15-1318 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/28/2020 10:36 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,494,874		6,494,874	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)	6,494,874		6,494,874	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,215,408		1,215,408	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,215,408		1,215,408	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,710,282		7,710,282	17.00
18.00	Ancillary services	37,677,876	95,852,317	133,530,193	18.00
19.00	Outpatient services	3,256,319	23,894,749	27,151,068	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	0	8,044,648	8,044,648	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	48,644,477	127,791,714	176,436,191	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,010,586		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)		34,010,586		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1318	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 8/28/2020 10:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	176,436,191	1.00
2.00	Less contractual allowances and discounts on patients' accounts	146,913,944	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,522,247	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,010,586	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,488,339	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	189,342	24.00
25.00	Total other income (sum of lines 6-24)	189,342	25.00
26.00	Total (line 5 plus line 25)	-4,298,997	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,298,997	29.00