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: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 5/18/2020 9:36 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/18/2020 Time: 9:36 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL (15-0030) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DARIN BROWN
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	35,127	16,696	0	-132,391	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		275,065		0	10.00
10.01	RURAL HEALTH CLINIC II	0		45,979		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	35,127	337,741	0	-132,391	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2020 9:36 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 NORTH 16TH STREET	PO Box:			1.00
2.00	City: NEW CASTLE	State: IN	Zip Code: 47392-	County: HENRY	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	HENRY COUNTY MEMORIAL HOSPITAL	150030	99915	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HCMH HOME CARE	157430	99915		06/14/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSP-BASED HOSPICE	151564	99915		08/31/1998				14.00
15.00	Hospital-Based Health Clinic - RHC	NEW CASTLE FAMILY AND INTERNAL MED	158520	99915		04/11/2017	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	NCFIM - NORHTFIELD PARK	158525	99915		12/04/2017	N	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2020 9:36 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	
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.	187	1,252	0	0	456	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	01/01/2019	12/31/2019	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)	Y	Y	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.	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2020 9:36 am

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

		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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2020 9:36 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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	460,593	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2020 9:36 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:	Contractor's Name:		Contractor's Number:	141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:		Zip Code:	143.00

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

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

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

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

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

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

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

		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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2020 9:36 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)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/28/2020	Y	02/28/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2020 9:36 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.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		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.	KYLE		SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 5/18/2020 9:36 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.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 5/18/2020 9:36 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	38	13,870	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,870	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		48	17,520	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		48				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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2020 9:36 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)	2,349	187	6,168			1.00
2.00	HMO and other (see instructions)	1,772	1,704				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,349	187	6,168			7.00
8.00	INTENSIVE CARE UNIT	626	0	1,476			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		0	706			13.00
14.00	Total (see instructions)	2,975	187	8,350	0.00	309.48	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	4,622	120	10,731	0.00	13.66	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	5.10	24.00
24.10	HOSPICE (non-distinct part)			44			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	8,070	3,906	26,972	0.00	53.95	26.00
26.01	RURAL HEALTH CLINIC II	5,556	16,220	44,979	0.00	74.42	26.01
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	456.61	27.00
28.00	Observation Bed Days		195	1,083			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	4	38			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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2020 9:36 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	845	47	2,290	1.00
2.00	HMO and other (see instructions)			463	432		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	845	47	2,290	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 5/18/2020 9:36 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	44,852,155	-29,586	44,822,569	1,284,537.00	34.89	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		15,000	0	15,000	180.00	83.33	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		4,489,175	0	4,489,175	34,262.00	131.02	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		9,423,396	0	9,423,396	260,814.00	36.13	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,275,352	209,700	3,485,052	108,493.00	32.12	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,134,824	0	1,134,824	21,183.00	53.57	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		171,846	0	171,846	1,421.00	120.93	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,807,593	0	10,807,593			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		622,451	0	622,451			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		2,864	0	2,864			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		635,314	0	635,314			23.00
24.00	Wage-related costs (RHC/FQHC)		3,002,577	0	3,002,577			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	270,812	0	270,812	9,038.00	29.96	26.00
27.00	Administrative & General	5.00	5,808,991	0	5,808,991	146,683.00	39.60	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 5/18/2020 9:36 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		255,685	0	255,685	1,173.00	217.98	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,199,908	0	1,199,908	45,084.00	26.61	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	520,475	-21,298	499,177	38,695.00	12.90	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	834,475	-580,415	254,060	14,013.00	18.13	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	346,140	346,140	19,092.00	18.13	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,088,668	25,000	2,113,668	52,517.00	40.25	38.00
39.00	Central Services and Supply	14.00	468,541	0	468,541	16,288.00	28.77	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	682,290	0	682,290	31,522.00	21.64	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 5/18/2020 9:36 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		31,195,269	-29,586	31,165,683	990,634.00	31.46	1.00
2.00	Excluded area salaries (see instructions)		3,275,352	209,700	3,485,052	108,493.00	32.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)		27,919,917	-239,286	27,680,631	882,141.00	31.38	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,306,670	0	1,306,670	22,604.00	57.81	4.00
5.00	Subtotal wage-related costs (see inst.)		10,810,457	0	10,810,457	0.00	39.05	5.00
6.00	Total (sum of lines 3 thru 5)		40,037,044	-239,286	39,797,758	904,745.00	43.99	6.00
7.00	Total overhead cost (see instructions)		12,129,845	-230,573	11,899,272	374,105.00	31.81	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part IV Date/Time Prepared: 5/18/2020 9:36 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,869,814	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)	9,021,506	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	118,111	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	200,707	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	561,910	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	283,375	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,980,825	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	14,551	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	20,000	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,070,799	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part V Date/Time Prepared: 5/18/2020 9:36 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-4 | Date/Time Prepared: 5/18/2020 9:36 am

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	259.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		3.95	0.00	3.95	4.00
5.00	Other Administrative Personnel		1.49	0.00	1.49	5.00
6.00	Direct Nursing Service		44.50	0.00	44.50	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		25.98	0.00	25.98	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		2.61	0.00	2.61	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.08	0.00	0.08	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		6.14	0.00	6.14	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		17140			20.00
20.01			26900			20.01
20.02			34620			20.02
20.03			99915			20.03

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,727	183	61	3	1,974	21.00
22.00	Skilled Nursing Visit Charges	543,226	57,099	19,283	969	620,577	22.00
23.00	Physical Therapy Visits	2,096	32	14	8	2,150	23.00
24.00	Physical Therapy Visit Charges	675,343	10,336	4,522	2,584	692,785	24.00
25.00	Occupational Therapy Visits	142	11	0	0	153	25.00
26.00	Occupational Therapy Visit Charges	44,227	3,487	0	0	47,714	26.00
27.00	Speech Pathology Visits	34	5	0	0	39	27.00
28.00	Speech Pathology Visit Charges	10,639	1,454	0	0	12,093	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	290	16	0	0	306	31.00
32.00	Home Health Aide Visit Charges	43,912	2,432	0	0	46,344	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,289	247	75	11	4,622	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,317,347	74,808	23,805	3,553	1,419,513	35.00
36.00	Total Number of Episodes (standard/non outlier)	273		23	1	297	36.00
37.00	Total Number of Outlier Episodes		8		0	8	37.00
38.00	Total Non-Routine Medical Supply Charges	3,217	432	165	0	3,814	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 5/18/2020 9:36 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			2200 FOREST RIDGE PARKWAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEW CASTLE		IN	47362	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

			1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N	0	13.00
			Provider name	CCN number	
			1.00	2.00	
14.00	RHC/FQHC name, CCN number				14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2019 To 12/31/2019	Worksheet S-8 Date/Time Prepared: 5/18/2020 9:36 am
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 5/18/2020 9:36 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			152 WITTENBRAKER AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEW CASTLE		IN	47362	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	19:00	08:00	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0030
Component CCN: 15-8525

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

Worksheet S-8
Date/Time Prepared:
5/18/2020 9:36 am

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00	08:00	19:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/18/2020 9:36 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	3,167	36	930	4,133	11.00
12.00	Hospice Inpatient Respite Care	21	0	4	25	12.00
13.00	Hospice General Inpatient Care	14	2	0	16	13.00
14.00	Total Hospice Days	3,202	38	934	4,174	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	21	0	0	21	15.00
16.00	Hospice General Inpatient Care	14	2	0	16	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 5/18/2020 9:36 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.306616	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,683,684	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	34,447,511	6.00
7.00	Medicaid cost (line 1 times line 6)	10,562,158	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)	5,878,474	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)	5,878,474	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,003,128	608,344	1,611,472	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	307,575	608,344	915,919	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)	307,575	608,344	915,919	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	9,598,943	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	225,162	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	346,402	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,252,541	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,958,217	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,874,136	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,752,610	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 5/18/2020 9:36 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	NEW CAP REL COSTS-BLDG & FIXT		5,857,955	5,857,955	-92,352	5,765,603	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	459,446	459,446	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	270,812	10,941,665	11,212,477	2,006,498	13,218,975	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,808,991	10,232,965	16,041,956	-2,115	16,039,841	5.00
7.00	00700	OPERATION OF PLANT	1,199,908	1,653,163	2,853,071	0	2,853,071	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	405,580	405,580	0	405,580	8.00
9.00	00900	HOUSEKEEPING	520,475	343,633	864,108	-35,360	828,748	9.00
10.00	01000	DIETARY	834,475	617,877	1,452,352	-1,010,176	442,176	10.00
11.00	01100	CAFETERIA	0	0	0	602,435	602,435	11.00
13.00	01300	NURSING ADMINISTRATION	2,088,668	219,095	2,307,763	25,000	2,332,763	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	468,541	405,276	873,817	0	873,817	14.00
15.00	01500	PHARMACY	0	4,686,338	4,686,338	-292,222	4,394,116	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	682,290	154,976	837,266	-419	836,847	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,674,995	1,409,026	7,084,021	-838,412	6,245,609	30.00
31.00	03100	INTENSIVE CARE UNIT	1,220,496	268,604	1,489,100	-900	1,488,200	31.00
43.00	04300	NURSERY	0	0	0	639,565	639,565	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,340,735	9,038,953	13,379,688	-7,576,646	5,803,042	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	164,873	164,873	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,591,679	909,366	2,501,045	-273,381	2,227,664	54.00
57.00	05700	CT SCAN	178,876	920,548	1,099,424	0	1,099,424	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	106,917	481,880	588,797	0	588,797	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,929,328	2,288,178	4,217,506	0	4,217,506	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	624,926	196,718	821,644	-5,099	816,545	65.00
66.00	06600	PHYSICAL THERAPY	1,511,352	997,487	2,508,839	-515	2,508,324	66.00
67.00	06700	OCCUPATIONAL THERAPY	203,150	14,822	217,972	0	217,972	67.00
68.00	06800	SPEECH PATHOLOGY	86,959	6,093	93,052	0	93,052	68.00
69.00	06900	ELECTROCARDIOLOGY	182,664	173,135	355,799	0	355,799	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-302,423	-302,423	1,838,701	1,536,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,439,211	5,439,211	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	119,437	20,749	140,186	0	140,186	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,614,020	1,740,309	5,354,329	-699,380	4,654,949	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,827,503	3,207,903	9,035,406	-727,573	8,307,833	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,489,606	1,000,005	3,489,611	0	3,489,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,072,631	357,622	1,430,253	-12,023	1,418,230	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	422,222	349,345	771,567	-4,770	766,797	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,071,656	58,596,843	101,668,499	-395,614	101,272,885	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	1,109,599	664,108	1,773,707	-71,755	1,701,952	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	92,352	92,352	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	169,011	169,011	0	169,011	194.05
194.06	07956	DR AFZAL	0	8,681	8,681	0	8,681	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	443,101	443,101	194.09
194.10	07960	CAMBRIDGE CITY	434,615	255,558	690,173	-56,097	634,076	194.10
194.11	07961	WELL BEING	70,401	39,774	110,175	-10,169	100,006	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	66,122	66,122	0	66,122	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	165,884	1,555,995	1,721,879	-1,818	1,720,061	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	44,852,155	61,356,092	106,208,247	0	106,208,247	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-137,542	5,628,061		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	459,446		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,878,057	16,097,032		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,812,252	13,227,589		5.00
7.00	00700	OPERATION OF PLANT	0	2,853,071		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	405,580		8.00
9.00	00900	HOUSEKEEPING	0	828,748		9.00
10.00	01000	DIETARY	-24,181	417,995		10.00
11.00	01100	CAFETERIA	-418,154	184,281		11.00
13.00	01300	NURSING ADMINISTRATION	90,721	2,423,484		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	873,817		14.00
15.00	01500	PHARMACY	-977,282	3,416,834		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,700	831,147		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,166,516	4,079,093		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,488,200		31.00
43.00	04300	NURSERY	0	639,565		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,583,646	3,219,396		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	164,873		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,605	2,226,059		54.00
57.00	05700	CT SCAN	-619,692	479,732		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-295,228	293,569		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-29,362	4,188,144		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	-27,588	788,957		65.00
66.00	06600	PHYSICAL THERAPY	-818,003	1,690,321		66.00
67.00	06700	OCCUPATIONAL THERAPY	-30	217,942		67.00
68.00	06800	SPEECH PATHOLOGY	0	93,052		68.00
69.00	06900	ELECTROCARDIOLOGY	0	355,799		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,536,278		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,439,211		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	CARDIAC REHAB	0	140,186		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-419,803	4,235,146		88.00
88.01	08801	RURAL HEALTH CLINIC II	-1,910,839	6,396,994		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-16,318	3,473,293		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-15,142	1,403,088		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	-14,555	752,242		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,324,660	90,948,225		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,701,952		192.00
194.00	07950	HOSPITALIST	0	0		194.00
194.01	07951	RENTAL	0	92,352		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	169,011		194.05
194.06	07956	DR AFZAL	0	8,681		194.06
194.07	07957	PHILLIPS HALL	0	0		194.07
194.08	07958	OB DRS	0	0		194.08
194.09	07959	THE WATERS	0	443,101		194.09
194.10	07960	CAMBRIDGE CITY	0	634,076		194.10
194.11	07961	WELL BEING	0	100,006		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	66,122		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	1,720,061		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0		194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,324,660	95,883,587		200.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 5/18/2020 9:36 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB/NURSERY/L&D				
1.00	NURSERY	43.00	556,888	82,677	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	143,560	21,313	2.00
	0		700,448	103,990	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	346,140	256,295	1.00
	0		346,140	256,295	
	C - WATERS EXCLUSIONS				
1.00	THE WATERS	194.09	255,573	187,528	1.00
2.00		0.00	0	0	2.00
	0		255,573	187,528	
	D - DEPRECIATION POB				
1.00	RENTAL	194.01	0	92,352	1.00
	0		0	92,352	
	E - EQUIPMENT RENTAL				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	459,446	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
	0		0	459,446	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00		5,439,211	1.00
	0		0	5,439,211	
	H - VERO				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	29,586	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	29,586	
	I - MEDICAL DIRECTOR RECLASS				
1.00	NURSING ADMINISTRATION	13.00	25,000	0	1.00
	0		25,000	0	
	L - MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,277,912	1.00
	0		0	7,277,912	
	M - FOREST RIDGE STAFF RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	15,146	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	97,848	0	2.00
	0		112,994	0	
	N - NORTHFIELD STAFF RECLASS				
1.00	RURAL HEALTH CLINIC II	88.01	5,727	0	1.00
	0		5,727	0	
	O - BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,976,912	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
	0		0	1,976,912	
500.00	Grand Total: Increases		1,445,882	15,823,232	500.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 5/18/2020 9:36 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB/NURSERY/L&D						
1.00	ADULTS & PEDIATRICS	30.00	700,448	103,990	0		1.00
2.00		0.00	0	0	0		2.00
	0		700,448	103,990			
	B - CAFETERIA						
1.00	DIETARY	10.00	346,140	256,295	0		1.00
	0		346,140	256,295			
	C - WATERS EXCLUSIONS						
1.00	HOUSEKEEPING	9.00	21,298	14,062	0		1.00
2.00	DIETARY	10.00	234,275	173,466	0		2.00
	0		255,573	187,528			
	D - DEPRECIATION POB						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	92,352	9		1.00
	0		0	92,352			
	E - EQUIPMENT RENTAL						
1.00	PHARMACY	15.00	0	98,811	9		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	419	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	900	0		3.00
4.00	OPERATING ROOM	50.00	0	84,857	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	273,381	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	563	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	515	0		7.00
	0		0	459,446			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,439,211	0		1.00
	0		0	5,439,211			
	H - VERO						
1.00	ADULTS & PEDIATRICS	30.00	25,050	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	4,536	0	0		2.00
	TOTALS		29,586	0			
	I - MEDICAL DIRECTOR RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	25,000	0	0		1.00
	0		25,000	0			
	L - MED SUPPLIES RECLASS						
1.00	OPERATING ROOM	50.00	0	7,277,912	0		1.00
	0		0	7,277,912			
	M - FOREST RIDGE STAFF RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	97,848	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	15,146	0	0		2.00
	0		112,994	0			
	N - NORTHFIELD STAFF RECLASS						
1.00	CAMBRIDGE CITY	194.10	5,727	0	0		1.00
	0		5,727	0			
	O - BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,115	0		1.00
2.00	PHARMACY	15.00	0	193,411	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	8,924	0		3.00
4.00	OPERATING ROOM	50.00	0	213,877	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	616,678	0		5.00
6.00	RURAL HEALTH CLINIC II	88.01	0	831,148	0		6.00
7.00	HOME HEALTH AGENCY	101.00	0	12,023	0		7.00
8.00	HOSPICE	116.00	0	4,770	0		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	31,609	0		9.00
10.00	CAMBRIDGE CITY	194.10	0	50,370	0		10.00
11.00	WELL BEING	194.11	0	10,169	0		11.00
12.00	HENRY COUNTY RADIOLOGY	194.14	0	1,818	0		12.00
	0		0	1,976,912			
500.00	Grand Total: Decreases		1,475,468	15,793,646			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I Date/Time Prepared: 5/18/2020 9:36 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	46,000	0	0	0	0	1.00
2.00	Land Improvements	2,081,914	13,598	0	13,598	0	2.00
3.00	Buildings and Fixtures	42,241,336	2,261,750	0	2,261,750	1,243,352	3.00
4.00	Building Improvements	1,115,708	354,873	0	354,873	0	4.00
5.00	Fixed Equipment	17,368,753	659,853	0	659,853	2,350,941	5.00
6.00	Movable Equipment	41,109,127	2,796,501	0	2,796,501	669,917	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	103,962,838	6,086,575	0	6,086,575	4,264,210	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	103,962,838	6,086,575	0	6,086,575	4,264,210	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	46,000	0	1.00
2.00	Land Improvements	2,095,512	0	2.00
3.00	Buildings and Fixtures	43,259,734	0	3.00
4.00	Building Improvements	1,470,581	0	4.00
5.00	Fixed Equipment	15,677,665	0	5.00
6.00	Movable Equipment	43,235,711	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	105,785,203	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	105,785,203	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 5/18/2020 9:36 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	NEW CAP REL COSTS-BLDG & FIXT	5,468,329	0	389,626	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,468,329	0	389,626	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,857,955		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	5,857,955		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 5/18/2020 9:36 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	NEW CAP REL COSTS-BLDG & FIXT	44,850,428	0	44,850,428	0.429673	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	59,532,356	0	59,532,356	0.570327	0	2.00
3.00	Total (sum of lines 1-2)	104,382,784	0	104,382,784	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	5,375,977	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	459,446	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,835,423	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	252,084	0	0	0	5,628,061	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	459,446	2.00
3.00	Total (sum of lines 1-2)	252,084	0	0	0	6,087,507	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 5/18/2020 9:36 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	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-137,542	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-12,491	ADMINISTRATIVE & GENERAL	5.00	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	-25,254	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,797,313			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	-2,590,191			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-353,436	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	-5,700	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 5/18/2020 9:36 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OP REV - HUMAN RESOURSEC - MIS	B	-418	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00	OTHER OP REV - HUMAN RESOURSEC - INC	B	-24,523	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
36.00	OTHER OP REV - PHY REAPP FEES	B	-24,000	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01	DIETARY-OTHER OP REV	B	-6,989	DIETARY	10.00	0	36.01
36.02	OTHER OP REV - DIETARY TRANSFERS	B	-17,192	DIETARY	10.00	0	36.02
38.00	OTHER OP REV - DIETARY - OUTSIDE SAL	B	-64,718	CAFETERIA	11.00	0	38.00
38.01	OTHER OP REV - PHARMACY	B	-977,282	PHARMACY	15.00	0	38.01
38.02	OTHER OP REV - HEALTH PROGRAM	B	-218	ADULTS & PEDIATRICS	30.00	0	38.02
40.00	OTHER OP REV - MEDICAL RECORDS	B	-2,436	OPERATING ROOM	50.00	0	40.00
40.01	CT SCAN-OTHER OP REV	B	-147	CT SCAN	57.00	0	40.01
40.02	OTHER OP REV - LABORATORY-LAB DRUG S	B	-1,366	LABORATORY	60.00	0	40.02
40.03	OTHER OP REV - AQUATICS - HLTH PROG	B	-17,203	PHYSICAL THERAPY	66.00	0	40.03
41.00	OTHER OP REV - ATH TRAINING - HLTH P	B	-68,067	PHYSICAL THERAPY	66.00	0	41.00
42.00	OTHER OP REV - ATH TRAINING - OUTSID	B	-6,306	PHYSICAL THERAPY	66.00	0	42.00
43.00	OTHER OP REV - PHYSICAL THER - EE	B	-10,629	PHYSICAL THERAPY	66.00	0	43.00
44.00	OTHER OP REV - PHYSICAL THER - FIT F	B	-94,558	PHYSICAL THERAPY	66.00	0	44.00
44.01	OTHER OP REV - PHYSICAL THER - HEALT	B	-30	OCCUPATIONAL THERAPY	67.00	0	44.01
44.02	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-480	RURAL HEALTH CLINIC	88.00	0	44.02
45.00	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-1,120	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	OTHER OP REV - NORTHFIELD PARK	B	-44,365	RURAL HEALTH CLINIC II	88.01	0	45.01
45.02	RENT & SERVICES - NCFIM @ NORTHFIELD	B	-268	RURAL HEALTH CLINIC II	88.01	0	45.02
45.03	OTHER OP REV - NEW CASTLE IMMEDIATE	B	-1,014	RURAL HEALTH CLINIC II	88.01	0	45.03
45.04	OTHER OP REV - NEW CASTLE PEDIATRICS	B	-47,717	RURAL HEALTH CLINIC II	88.01	0	45.04
45.05	OTHER OP REV - NEW CASTLE PEDIATRICS	B	-490	RURAL HEALTH CLINIC II	88.01	0	45.05
45.06	PUBLIC RELATIONS	A	-2,652	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.06
45.07	PUBLIC RELATIONS	A	-88,723	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	PUBLIC RELATIONS	A	-125	NURSING ADMINISTRATION	13.00	0	45.08
45.09	PUBLIC RELATIONS	A	-1,605	RADIOLOGY-DIAGNOSTIC	54.00	0	45.09
45.10	PUBLIC RELATIONS	A	-986	PHYSICAL THERAPY	66.00	0	45.10
45.11	PUBLIC RELATIONS	A	-5,983	RURAL HEALTH CLINIC	88.00	0	45.11
45.12	PUBLIC RELATIONS	A	-20,896	RURAL HEALTH CLINIC II	88.01	0	45.12
45.16	PUBLIC RELATIONS	A	-8,818	EMERGENCY	91.00	0	45.16
45.17	PUBLIC RELATIONS	A	-1,016	HOME HEALTH AGENCY	101.00	0	45.17
45.18	PUBLIC RELATIONS	A	-426	HOSPICE	116.00	0	45.18
45.19	AHA & IHA DUES	A	-7,333	ADMINISTRATIVE & GENERAL	5.00	0	45.19
46.00	BENEFIT EXPENSE	A	2,905,650	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46.00
46.01	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-136,761	RURAL HEALTH CLINIC	88.00	0	46.01
46.02	MEDICAL DIRECTOR	A	90,846	NURSING ADMINISTRATION	13.00	0	46.02
46.03	HAF EXPENSE	A	-2,604,666	ADMINISTRATIVE & GENERAL	5.00	0	46.03
46.04	PHYSICIAN RECRUITMENT	A	-27,235	ADMINISTRATIVE & GENERAL	5.00	0	46.04
46.05	PHYSICIAN RECRUITMENT	A	-31,718	ADULTS & PEDIATRICS	30.00	0	46.05
46.06	PHYSICIAN RECRUITMENT	A	-41,250	OPERATING ROOM	50.00	0	46.06
46.07	PHYSICIAN RECRUITMENT	A	-7,500	EMERGENCY	91.00	0	46.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,324,660				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.

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 5/18/2020 9:36 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	

(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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 5/18/2020 9:36 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	57.00	CT SCAN	CT SCAN-PAID TO FND	207,505	827,050	1.00
2.00	58.00	MAGNETIC RESONANCE IMAGING (	MRI-PAID TO FND	154,772	450,000	2.00
3.00	66.00	PHYSICAL THERAPY	PHYSICAL THERAPY-RENT	164,368	784,622	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION-RENT	0	22,550	3.01
4.00	65.00	RESPIRATORY THERAPY	SLEEP LAB-RENT	22,090	49,678	4.00
4.01	88.00	RURAL HEALTH CLINIC	NC FAMILY INTERNAL MEDICINE-	220,565	496,024	4.01
4.02	88.01	RURAL HEALTH CLINIC II	NCFIM @ NORTHFIELD PARK-RENT	329,431	737,171	4.02
4.03	88.01	RURAL HEALTH CLINIC II	NCFIM @ NORTHFIELD PARK-RENT	69,950	156,528	4.03
4.04	88.01	RURAL HEALTH CLINIC II	NCFIM @ NORTHFIELD PARK-RENT	144,330	323,328	4.04
4.05	101.00	HOME HEALTH AGENCY	HOME CARE-RENT	7,849	21,975	4.05
4.06	116.00	HOSPICE	HOSPICE-RENT	7,846	21,975	4.06
4.07	60.00	LABORATORY	LABORATORY- RENT	5,443	33,439	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,334,149	3,924,340	5.00

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

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

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

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

6.00	G	HENRY COUNTY HO	100.00	HOSPITAL FOUNDA	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC				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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 5/18/2020 9:36 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	-619,545	0		1.00
2.00	-295,228	0		2.00
3.00	-620,254	0		3.00
3.01	-22,550	0		3.01
4.00	-27,588	0		4.00
4.01	-275,459	0		4.01
4.02	-407,740	0		4.02
4.03	-86,578	0		4.03
4.04	-178,998	0		4.04
4.05	-14,126	0		4.05
4.06	-14,129	0		4.06
4.07	-27,996	0		4.07
5.00	-2,590,191			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	MISC		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 5/18/2020 9:36 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	60.00	LABORATORY	56,000	0	56,000	260,300	588	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,134,580	2,134,580	0	211,500	0	2.00
3.00	50.00	OPERATING ROOM	2,539,960	2,539,960	0	239,400	0	3.00
4.00	88.01	RURAL HEALTH CLINIC II	1,122,773	1,122,773	0	211,500	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,853,313	5,797,313	56,000		588	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	60.00	LABORATORY	73,585	3,679	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			73,585	3,679	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	60.00	LABORATORY	0	73,585	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,134,580		2.00
3.00	50.00	OPERATING ROOM	0	0	0	2,539,960		3.00
4.00	88.01	RURAL HEALTH CLINIC II	0	0	0	1,122,773		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	73,585	0	5,797,313		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,628,061	5,628,061				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	459,446		459,446			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,097,032	33,679	2,612	16,133,323		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,227,589	778,291	60,363	2,103,581	16,169,824	5.00
7.00	00700	OPERATION OF PLANT	2,853,071	1,488,571	115,450	434,517	4,891,609	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	405,580	74,381	5,769	0	485,730	8.00
9.00	00900	HOUSEKEEPING	828,748	43,202	3,351	180,764	1,056,065	9.00
10.00	01000	DIETARY	417,995	156,937	12,172	92,001	679,105	10.00
11.00	01100	CAFETERIA	184,281	42,876	3,325	125,346	355,828	11.00
13.00	01300	NURSING ADMINISTRATION	2,423,484	86,187	6,684	765,412	3,281,767	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	873,817	155,523	12,062	169,670	1,211,072	14.00
15.00	01500	PHARMACY	3,416,834	33,962	2,634	0	3,453,430	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	831,147	59,900	4,646	247,074	1,142,767	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,079,093	646,227	50,120	1,792,337	6,567,777	30.00
31.00	03100	INTENSIVE CARE UNIT	1,488,200	252,233	19,563	441,972	2,201,968	31.00
43.00	04300	NURSERY	639,565	66,706	5,174	201,663	913,108	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,219,396	358,923	27,837	1,571,889	5,178,045	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	164,873	33,896	2,629	51,987	253,385	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,226,059	246,167	19,092	576,387	3,067,705	54.00
57.00	05700	CT SCAN	479,732	9,523	739	64,775	554,769	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	293,569	11,632	902	38,717	344,820	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,188,144	179,614	13,930	698,658	5,080,346	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	788,957	37,745	2,927	224,659	1,054,288	65.00
66.00	06600	PHYSICAL THERAPY	1,690,321	21,547	1,671	547,298	2,260,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,942	5,566	432	73,566	297,506	67.00
68.00	06800	SPEECH PATHOLOGY	93,052	4,196	325	31,490	129,063	68.00
69.00	06900	ELECTROCARDIOLOGY	355,799	0	0	66,147	421,946	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,536,278	0	0	0	1,536,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,439,211	0	0	0	5,439,211	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	140,186	15,459	1,199	43,251	200,095	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,235,146	0	0	1,278,779	5,513,925	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,396,994	0	0	2,147,809	8,544,803	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	3,473,293	229,774	17,821	901,549	4,622,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,403,088	0	0	388,427	1,791,515	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	752,242	0	0	152,897	905,139	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,948,225	5,072,717	393,429	15,412,622	89,606,163	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,938	0	0	21,938	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,701,952	0	0	387,276	2,089,228	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	92,352	0	24,647	0	116,999	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	169,011	0	0	0	169,011	194.05
194.06	07956	DR AFZAL	8,681	0	0	0	8,681	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	443,101	533,406	41,370	92,549	1,110,426	194.09
194.10	07960	CAMBRIDGE CITY	634,076	0	0	155,311	789,387	194.10
194.11	07961	WELL BEING	100,006	0	0	25,494	125,500	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	66,122	0	0	0	66,122	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	1,720,061	0	0	60,071	1,780,132	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	95,883,587	5,628,061	459,446	16,133,323	95,883,587	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,169,824					5.00
7.00	00700	OPERATION OF PLANT	992,258	5,883,867				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	98,530	93,442	677,702			8.00
9.00	00900	HOUSEKEEPING	214,222	54,273	28,757	1,353,317		9.00
10.00	01000	DIETARY	137,756	197,153	7,724	38,400	1,060,138	10.00
11.00	01100	CAFETERIA	72,179	53,863	0	11,687	0	11.00
13.00	01300	NURSING ADMINISTRATION	665,703	108,273	0	8,348	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	245,665	195,378	0	5,724	0	14.00
15.00	01500	PHARMACY	700,525	42,665	0	10,018	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	231,809	75,250	0	4,770	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,332,267	811,830	136,511	356,814	855,433	30.00
31.00	03100	INTENSIVE CARE UNIT	446,667	316,871	30,841	81,094	204,705	31.00
43.00	04300	NURSERY	185,223	83,800	11,007	6,440	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,050,361	450,901	121,846	176,976	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,399	42,583	2,837	10,972	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,281	309,250	49,315	52,234	0	54.00
57.00	05700	CT SCAN	112,534	11,964	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	69,946	14,613	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,030,543	225,642	857	33,392	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	213,861	90,546	0	34,346	0	65.00
66.00	06600	PHYSICAL THERAPY	458,609	708,255	13,259	97,790	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	60,349	6,992	1,666	12,403	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,180	5,272	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	85,591	0	0	6,201	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	311,632	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,103,339	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	40,589	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,118,494	430,634	4,213	36,492	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,733,271	1,113,131	0	131,897	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	937,657	288,655	121,400	111,385	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	363,407	62,549	0	9,540	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	183,607	62,522	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,896,454	5,856,307	530,233	1,236,923	1,060,138	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,450	27,560	0	3,101	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	423,798	0	336	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	23,733	0	0	105,184	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	34,284	0	14,350	0	0	194.05
194.06	07956	DR AFZAL	1,761	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	5,503	8,109	0	194.07
194.08	07958	OB DRS	0	0	9,094	0	0	194.08
194.09	07959	THE WATERS	225,249	0	118,186	0	0	194.09
194.10	07960	CAMBRIDGE CITY	160,126	0	0	0	0	194.10
194.11	07961	WELL BEING	25,458	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	13,413	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	361,098	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	16,169,824	5,883,867	677,702	1,353,317	1,060,138	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	493,557					11.00
13.00	01300	NURSING ADMINISTRATION	40,061	4,104,152				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,820	0	1,670,659			14.00
15.00	01500	PHARMACY	0	0	2,740	4,209,378		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,037	0	2,572	0	1,481,205	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,738	806,430	31,680	0	157,746	30.00
31.00	03100	INTENSIVE CARE UNIT	25,639	230,409	14,079	0	84,029	31.00
43.00	04300	NURSERY	9,615	86,403	9,679	0	58,820	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,111	648,024	100,379	0	284,554	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,205	28,801	2,495	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,857	0	31,631	0	214,274	54.00
57.00	05700	CT SCAN	3,205	0	12,981	0	78,300	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,205	0	3,160	0	14,896	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	52,881	0	191,272	0	227,261	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	14,422	0	5,172	0	11,840	65.00
66.00	06600	PHYSICAL THERAPY	40,061	0	7,178	0	9,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,807	0	0	0	1,146	67.00
68.00	06800	SPEECH PATHOLOGY	1,602	0	0	0	382	68.00
69.00	06900	ELECTROCARDIOLOGY	3,205	0	7,668	0	12,222	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	292,264	0	27,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	884,883	0	41,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,209,378	0	73.00
76.00	03950	CARDIAC REHAB	3,205	28,801	525	0	1,528	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	763,228	6,661	0	12,986	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,036,838	11,288	0	20,625	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	52,881	475,218	44,617	0	213,892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	5,664	0	5,729	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	2,071	0	3,056	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	493,557	4,104,152	1,670,659	4,209,378	1,481,205	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	493,557	4,104,152	1,670,659	4,209,378	1,481,205	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,146,226	0	11,146,226		30.00
31.00	03100	INTENSIVE CARE UNIT	3,636,302	0	3,636,302		31.00
43.00	04300	NURSERY	1,364,095	0	1,364,095		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,083,197	0	8,083,197		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	395,677	0	395,677		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,383,547	0	4,383,547		54.00
57.00	05700	CT SCAN	773,753	0	773,753		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	450,640	0	450,640		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	6,842,194	0	6,842,194		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	1,424,475	0	1,424,475		65.00
66.00	06600	PHYSICAL THERAPY	3,595,156	0	3,595,156		66.00
67.00	06700	OCCUPATIONAL THERAPY	384,869	0	384,869		67.00
68.00	06800	SPEECH PATHOLOGY	162,499	0	162,499		68.00
69.00	06900	ELECTROCARDIOLOGY	536,833	0	536,833		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,167,293	0	2,167,293		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,469,066	0	7,469,066		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,209,378	0	4,209,378		73.00
76.00	03950	CARDIAC REHAB	274,743	0	274,743		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	7,886,633	0	7,886,633		88.00
88.01	08801	RURAL HEALTH CLINIC II	12,591,853	0	12,591,853		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	6,868,142	0	6,868,142		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	2,238,404	0	2,238,404		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,156,395	0	1,156,395		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,041,370	0	88,041,370		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	57,049	0	57,049		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,513,362	0	2,513,362		192.00
194.00	07950	HOSPITALIST	0	0	0		194.00
194.01	07951	RENTAL	245,916	0	245,916		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	217,645	0	217,645		194.05
194.06	07956	DR AFZAL	10,442	0	10,442		194.06
194.07	07957	PHILLIPS HALL	13,612	0	13,612		194.07
194.08	07958	OB DRS	9,094	0	9,094		194.08
194.09	07959	THE WATERS	1,453,861	0	1,453,861		194.09
194.10	07960	CAMBRIDGE CITY	949,513	0	949,513		194.10
194.11	07961	WELL BEING	150,958	0	150,958		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	79,535	0	79,535		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	2,141,230	0	2,141,230		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0		194.16
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	95,883,587	0	95,883,587		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,679	2,612	36,291	36,291	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	778,291	60,363	838,654	4,734	5.00
7.00	00700	OPERATION OF PLANT	0	1,488,571	115,450	1,604,021	978	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,381	5,769	80,150	0	8.00
9.00	00900	HOUSEKEEPING	0	43,202	3,351	46,553	407	9.00
10.00	01000	DIETARY	0	156,937	12,172	169,109	207	10.00
11.00	01100	CAFETERIA	0	42,876	3,325	46,201	282	11.00
13.00	01300	NURSING ADMINISTRATION	0	86,187	6,684	92,871	1,723	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	155,523	12,062	167,585	382	14.00
15.00	01500	PHARMACY	0	33,962	2,634	36,596	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	59,900	4,646	64,546	556	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	646,227	50,120	696,347	4,034	30.00
31.00	03100	INTENSIVE CARE UNIT	0	252,233	19,563	271,796	995	31.00
43.00	04300	NURSERY	0	66,706	5,174	71,880	454	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	358,923	27,837	386,760	3,538	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,896	2,629	36,525	117	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	246,167	19,092	265,259	1,297	54.00
57.00	05700	CT SCAN	0	9,523	739	10,262	146	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	11,632	902	12,534	87	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	179,614	13,930	193,544	1,572	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	37,745	2,927	40,672	506	65.00
66.00	06600	PHYSICAL THERAPY	0	21,547	1,671	23,218	1,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,566	432	5,998	166	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,196	325	4,521	71	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	149	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	15,459	1,199	16,658	97	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,878	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	4,814	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	229,774	17,821	247,595	2,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	874	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	344	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,072,717	393,429	5,466,146	34,669	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,938	0	21,938	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	872	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	24,647	24,647	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	533,406	41,370	574,776	208	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	350	194.10
194.11	07961	WELL BEING	0	0	0	0	57	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	135	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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	5,628,061	459,446	6,087,507	36,291	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	843,388					5.00
7.00	00700	OPERATION OF PLANT	51,753	1,656,752				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,139	26,311	111,600			8.00
9.00	00900	HOUSEKEEPING	11,173	15,282	4,736	78,151		9.00
10.00	01000	DIETARY	7,185	55,513	1,272	2,218	235,504	10.00
11.00	01100	CAFETERIA	3,765	15,167	0	675	0	11.00
13.00	01300	NURSING ADMINISTRATION	34,721	30,487	0	482	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,813	55,014	0	331	0	14.00
15.00	01500	PHARMACY	36,537	12,013	0	578	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,090	21,189	0	275	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,487	228,591	22,479	20,607	190,030	30.00
31.00	03100	INTENSIVE CARE UNIT	23,297	89,223	5,079	4,683	45,474	31.00
43.00	04300	NURSERY	9,661	23,596	1,813	372	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,784	126,963	20,065	10,220	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,681	11,990	467	634	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,456	87,077	8,121	3,016	0	54.00
57.00	05700	CT SCAN	5,869	3,369	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,648	4,115	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	53,750	63,535	141	1,928	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	11,154	25,496	0	1,983	0	65.00
66.00	06600	PHYSICAL THERAPY	23,920	199,427	2,183	5,647	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,148	1,969	274	716	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,365	1,484	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,464	0	0	358	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,254	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	57,547	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	2,117	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	58,337	121,256	694	2,107	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	90,422	313,430	0	7,617	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	48,905	81,278	19,992	6,432	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	18,954	17,612	0	551	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	9,576	17,605	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	776,972	1,648,992	87,316	71,430	235,504	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	232	7,760	0	179	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,104	0	55	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	1,238	0	0	6,074	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	1,788	0	2,363	0	0	194.05
194.06	07956	DR AFZAL	92	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	906	468	0	194.07
194.08	07958	OB DRS	0	0	1,498	0	0	194.08
194.09	07959	THE WATERS	11,748	0	19,462	0	0	194.09
194.10	07960	CAMBRIDGE CITY	8,352	0	0	0	0	194.10
194.11	07961	WELL BEING	1,328	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	700	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	18,834	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	843,388	1,656,752	111,600	78,151	235,504	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	66,090					11.00
13.00	01300	NURSING ADMINISTRATION	5,364	165,648				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,717	0	237,842			14.00
15.00	01500	PHARMACY	0	0	390	86,114		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,219	0	366	0	102,241	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,018	32,548	4,510	0	10,888	30.00
31.00	03100	INTENSIVE CARE UNIT	3,433	9,300	2,004	0	5,800	31.00
43.00	04300	NURSERY	1,287	3,487	1,378	0	4,060	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,656	26,155	14,290	0	19,643	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	429	1,162	355	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,935	0	4,503	0	14,790	54.00
57.00	05700	CT SCAN	429	0	1,848	0	5,405	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	429	0	450	0	1,028	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,081	0	27,231	0	15,687	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,931	0	736	0	817	65.00
66.00	06600	PHYSICAL THERAPY	5,364	0	1,022	0	633	66.00
67.00	06700	OCCUPATIONAL THERAPY	644	0	0	0	79	67.00
68.00	06800	SPEECH PATHOLOGY	215	0	0	0	26	68.00
69.00	06900	ELECTROCARDIOLOGY	429	0	1,092	0	844	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	41,608	0	1,872	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	125,976	0	2,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	86,114	0	73.00
76.00	03950	CARDIAC REHAB	429	1,162	75	0	105	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	30,805	948	0	896	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	41,849	1,607	0	1,424	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,081	19,180	6,352	0	14,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	806	0	395	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	295	0	211	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,090	165,648	237,842	86,114	102,241	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	66,090	165,648	237,842	86,114	102,241	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,291,539	0	1,291,539		30.00
31.00	03100	INTENSIVE CARE UNIT	461,084	0	461,084		31.00
43.00	04300	NURSERY	117,988	0	117,988		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	672,074	0	672,074		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,360	0	54,360		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,454	0	421,454		54.00
57.00	05700	CT SCAN	27,328	0	27,328		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,291	0	22,291		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	364,469	0	364,469		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	83,295	0	83,295		65.00
66.00	06600	PHYSICAL THERAPY	262,646	0	262,646		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,994	0	12,994		67.00
68.00	06800	SPEECH PATHOLOGY	7,682	0	7,682		68.00
69.00	06900	ELECTROCARDIOLOGY	7,336	0	7,336		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,734	0	59,734		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	186,397	0	186,397		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,114	0	86,114		73.00
76.00	03950	CARDIAC REHAB	20,643	0	20,643		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	217,921	0	217,921		88.00
88.01	08801	RURAL HEALTH CLINIC II	461,163	0	461,163		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	453,608	0	453,608		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	39,192	0	39,192		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	28,031	0	28,031		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,359,343	0	5,359,343		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,109	0	30,109		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,031	0	23,031		192.00
194.00	07950	HOSPITALIST	0	0	0		194.00
194.01	07951	RENTAL	31,959	0	31,959		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	4,151	0	4,151		194.05
194.06	07956	DR AFZAL	92	0	92		194.06
194.07	07957	PHILLIPS HALL	1,374	0	1,374		194.07
194.08	07958	OB DRS	1,498	0	1,498		194.08
194.09	07959	THE WATERS	606,194	0	606,194		194.09
194.10	07960	CAMBRIDGE CITY	8,702	0	8,702		194.10
194.11	07961	WELL BEING	1,385	0	1,385		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	700	0	700		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	18,969	0	18,969		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0		194.16
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	6,087,507	0	6,087,507		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	CAPITAL RELATED COSTS: NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS: NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	258,852					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		272,459				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,549	1,549	44,551,757			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,796	35,796	5,808,991	-16,169,824	79,713,763	5.00
7.00	00700	OPERATION OF PLANT	68,464	68,464	1,199,908	0	4,891,609	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	3,421	0	0	485,730	8.00
9.00	00900	HOUSEKEEPING	1,987	1,987	499,177	0	1,056,065	9.00
10.00	01000	DIETARY	7,218	7,218	254,060	0	679,105	10.00
11.00	01100	CAFETERIA	1,972	1,972	346,140	0	355,828	11.00
13.00	01300	NURSING ADMINISTRATION	3,964	3,964	2,113,668	0	3,281,767	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	7,153	468,541	0	1,211,072	14.00
15.00	01500	PHARMACY	1,562	1,562	0	0	3,453,430	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,755	2,755	682,290	0	1,142,767	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,722	29,722	4,949,497	0	6,567,777	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	11,601	1,220,496	0	2,201,968	31.00
43.00	04300	NURSERY	3,068	3,068	556,888	0	913,108	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,508	16,508	4,340,735	0	5,178,045	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	1,559	143,560	0	253,385	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	11,322	1,591,679	0	3,067,705	54.00
57.00	05700	CT SCAN	438	438	178,876	0	554,769	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	535	106,917	0	344,820	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,261	8,261	1,929,328	0	5,080,346	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,736	1,736	620,390	0	1,054,288	65.00
66.00	06600	PHYSICAL THERAPY	991	991	1,511,352	0	2,260,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	256	256	203,150	0	297,506	67.00
68.00	06800	SPEECH PATHOLOGY	193	193	86,959	0	129,063	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	182,664	0	421,946	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,536,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,439,211	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	711	711	119,437	0	200,095	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,531,318	0	5,513,925	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	5,931,078	0	8,544,803	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	10,568	10,568	2,489,606	0	4,622,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,072,631	0	1,791,515	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	422,222	0	905,139	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	233,310	233,310	42,561,558	-16,169,824	73,436,339	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	0	0	21,938	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,069,453	0	2,089,228	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	14,616	0	0	116,999	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	169,011	194.05
194.06	07956	DR AFZAL	0	0	0	0	8,681	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	24,533	24,533	255,573	0	1,110,426	194.09
194.10	07960	CAMBRIDGE CITY	0	0	428,888	0	789,387	194.10
194.11	07961	WELL BEING	0	0	70,401	0	125,500	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	66,122	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	165,884	0	1,780,132	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	5,628,061	459,446	16,133,323		16,169,824	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.742389	1.686294	0.362125		0.202849	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			36,291		843,388	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000815		0.010580	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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	215,415					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	705,361				8.00
9.00	00900	HOUSEKEEPING	1,987	29,931	5,674			9.00
10.00	01000	DIETARY	7,218	8,039	161	7,644		10.00
11.00	01100	CAFETERIA	1,972	0	49	0	308	11.00
13.00	01300	NURSING ADMINISTRATION	3,964	0	35	0	25	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	0	24	0	8	14.00
15.00	01500	PHARMACY	1,562	0	42	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,755	0	20	0	15	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,722	142,080	1,496	6,168	56	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	32,100	340	1,476	16	31.00
43.00	04300	NURSERY	3,068	11,456	27	0	6	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,508	126,819	742	0	45	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	2,953	46	0	2	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	51,328	219	0	23	54.00
57.00	05700	CT SCAN	438	0	0	0	2	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	0	0	0	2	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,261	892	140	0	33	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,315	0	144	0	9	65.00
66.00	06600	PHYSICAL THERAPY	25,930	13,800	410	0	25	66.00
67.00	06700	OCCUPATIONAL THERAPY	256	1,734	52	0	3	67.00
68.00	06800	SPEECH PATHOLOGY	193	0	0	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	26	0	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	2	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,766	4,385	153	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	40,753	0	553	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	10,568	126,355	467	0	33	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,290	0	40	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	2,289	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,406	551,872	5,186	7,644	308	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	13	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	350	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	441	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	14,936	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	5,728	34	0	0	194.07
194.08	07958	OB DRS	0	9,465	0	0	0	194.08
194.09	07959	THE WATERS	0	123,010	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	5,883,867	677,702	1,353,317	1,060,138	493,557	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.314101	0.960787	238.511984	138.688906	1,602.457792	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/18/2020 9:36 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1,656,752	111,600	78,151	235,504	66,090	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	7.690978	0.158217	13.773528	30.809001	214.577922	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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	285					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,269,192				14.00
15.00	01500	PHARMACY	0	16,840	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,811	0	3,878		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56	194,730	0	413		30.00
31.00	03100	INTENSIVE CARE UNIT	16	86,538	0	220		31.00
43.00	04300	NURSERY	6	59,493	0	154		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45	617,007	0	745		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2	15,337	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	194,426	0	561		54.00
57.00	05700	CT SCAN	0	79,792	0	205		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,426	0	39		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	1,175,707	0	595		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	31,794	0	31		65.00
66.00	06600	PHYSICAL THERAPY	0	44,120	0	24		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1		68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,132	0	32		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,796,479	0	71		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,439,211	0	109		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03950	CARDIAC REHAB	2	3,228	0	4		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	53	40,942	0	34		88.00
88.01	08801	RURAL HEALTH CLINIC II	72	69,385	0	54		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	33	274,249	0	560		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	34,817	0	15		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	12,728	0	8		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	285	10,269,192	100	3,878		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOSPITALIST	0	0	0	0		194.00
194.01	07951	RENTAL	0	0	0	0		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0		194.05
194.06	07956	DR AFZAL	0	0	0	0		194.06
194.07	07957	PHILLIPS HALL	0	0	0	0		194.07
194.08	07958	OB DRS	0	0	0	0		194.08
194.09	07959	THE WATERS	0	0	0	0		194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0		194.10
194.11	07961	WELL BEING	0	0	0	0		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0		194.16
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)	4,104,152	1,670,659	4,209,378	1,481,205		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14,400.533333	0.162687	42,093.780000	381.950748		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/18/2020 9:36 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	165,648	237,842	86,114	102,241		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	581.221053	0.023161	861.140000	26.364363		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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,146,226		11,146,226	0	11,146,226	30.00
31.00	03100	INTENSIVE CARE UNIT	3,636,302		3,636,302	0	3,636,302	31.00
43.00	04300	NURSERY	1,364,095		1,364,095	0	1,364,095	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,083,197		8,083,197	0	8,083,197	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	395,677		395,677	0	395,677	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,383,547		4,383,547	0	4,383,547	54.00
57.00	05700	CT SCAN	773,753		773,753	0	773,753	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	450,640		450,640	0	450,640	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	6,842,194		6,842,194	0	6,842,194	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,424,475	0	1,424,475	0	1,424,475	65.00
66.00	06600	PHYSICAL THERAPY	3,595,156	0	3,595,156	0	3,595,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	384,869	0	384,869	0	384,869	67.00
68.00	06800	SPEECH PATHOLOGY	162,499	0	162,499	0	162,499	68.00
69.00	06900	ELECTROCARDIOLOGY	536,833		536,833	0	536,833	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,167,293		2,167,293	0	2,167,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,469,066		7,469,066	0	7,469,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,209,378		4,209,378	0	4,209,378	73.00
76.00	03950	CARDIAC REHAB	274,743		274,743	0	274,743	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,886,633		7,886,633	0	7,886,633	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,591,853		12,591,853	0	12,591,853	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	6,868,142		6,868,142	0	6,868,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,664,788		1,664,788		1,664,788	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,238,404		2,238,404		2,238,404	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,156,395		1,156,395		1,156,395	116.00
200.00		Subtotal (see instructions)	89,706,158	0	89,706,158	0	89,706,158	200.00
201.00		Less Observation Beds	1,664,788		1,664,788		1,664,788	201.00
202.00		Total (see instructions)	88,041,370	0	88,041,370	0	88,041,370	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,760,914		12,760,914			30.00
31.00	03100	INTENSIVE CARE UNIT	5,150,156		5,150,156			31.00
43.00	04300	NURSERY	2,335,533		2,335,533			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,713,679	22,300,091	32,013,770	0.252491	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,155,729	1,183,167	2,338,896	0.169173	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,989,033	17,823,279	19,812,312	0.221254	0.000000	54.00
57.00	05700	CT SCAN	2,328,169	26,624,608	28,952,777	0.026725	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	477,305	7,805,364	8,282,669	0.054408	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	7,943,869	29,477,692	37,421,561	0.182841	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	4,061,171	2,582,723	6,643,894	0.214404	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	902,353	4,087,693	4,990,046	0.720466	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,018	432,979	626,997	0.613829	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	114,470	191,510	305,980	0.531077	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,448,252	5,277,105	6,725,357	0.079822	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,119,655	10,047,963	15,167,618	0.142889	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,773,774	7,288,479	23,062,253	0.323865	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,496,726	5,696,545	10,193,271	0.412957	0.000000	73.00
76.00	03950	CARDIAC REHAB	7,187	750,013	757,200	0.362841	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,178,570	7,178,570			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	11,378,764	11,378,764			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	4,786,575	39,096,209	43,882,784	0.156511	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	325,621	1,964,298	2,289,919	0.727007	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,222,883	3,222,883			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,644,651	1,644,651			116.00
200.00		Subtotal (see instructions)	81,084,189	206,054,586	287,138,775			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	81,084,189	206,054,586	287,138,775			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.252491	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.169173	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221254	54.00
57.00	05700	CT SCAN	0.026725	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.182841	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.214404	65.00
66.00	06600	PHYSICAL THERAPY	0.720466	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.613829	67.00
68.00	06800	SPEECH PATHOLOGY	0.531077	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079822	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.323865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.412957	73.00
76.00	03950	CARDIAC REHAB	0.362841	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
91.00	09100	EMERGENCY	0.156511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.727007	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/18/2020 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,146,226		11,146,226	0	11,146,226	30.00
31.00	03100	INTENSIVE CARE UNIT	3,636,302		3,636,302	0	3,636,302	31.00
43.00	04300	NURSERY	1,364,095		1,364,095	0	1,364,095	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,083,197		8,083,197	0	8,083,197	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	395,677		395,677	0	395,677	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,383,547		4,383,547	0	4,383,547	54.00
57.00	05700	CT SCAN	773,753		773,753	0	773,753	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	450,640		450,640	0	450,640	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	6,842,194		6,842,194	0	6,842,194	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,424,475	0	1,424,475	0	1,424,475	65.00
66.00	06600	PHYSICAL THERAPY	3,595,156	0	3,595,156	0	3,595,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	384,869	0	384,869	0	384,869	67.00
68.00	06800	SPEECH PATHOLOGY	162,499	0	162,499	0	162,499	68.00
69.00	06900	ELECTROCARDIOLOGY	536,833		536,833	0	536,833	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,167,293		2,167,293	0	2,167,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,469,066		7,469,066	0	7,469,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,209,378		4,209,378	0	4,209,378	73.00
76.00	03950	CARDIAC REHAB	274,743		274,743	0	274,743	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,886,633		7,886,633	0	7,886,633	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,591,853		12,591,853	0	12,591,853	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	6,868,142		6,868,142	0	6,868,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,664,788		1,664,788		1,664,788	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,238,404		2,238,404		2,238,404	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,156,395		1,156,395		1,156,395	116.00
200.00		Subtotal (see instructions)	89,706,158	0	89,706,158	0	89,706,158	200.00
201.00		Less Observation Beds	1,664,788		1,664,788		1,664,788	201.00
202.00		Total (see instructions)	88,041,370	0	88,041,370	0	88,041,370	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/18/2020 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,760,914		12,760,914			30.00
31.00	03100	INTENSIVE CARE UNIT	5,150,156		5,150,156			31.00
43.00	04300	NURSERY	2,335,533		2,335,533			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,713,679	22,300,091	32,013,770	0.252491	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,155,729	1,183,167	2,338,896	0.169173	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,989,033	17,823,279	19,812,312	0.221254	0.000000	54.00
57.00	05700	CT SCAN	2,328,169	26,624,608	28,952,777	0.026725	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	477,305	7,805,364	8,282,669	0.054408	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	7,943,869	29,477,692	37,421,561	0.182841	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	4,061,171	2,582,723	6,643,894	0.214404	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	902,353	4,087,693	4,990,046	0.720466	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,018	432,979	626,997	0.613829	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	114,470	191,510	305,980	0.531077	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,448,252	5,277,105	6,725,357	0.079822	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,119,655	10,047,963	15,167,618	0.142889	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,773,774	7,288,479	23,062,253	0.323865	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,496,726	5,696,545	10,193,271	0.412957	0.000000	73.00
76.00	03950	CARDIAC REHAB	7,187	750,013	757,200	0.362841	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,178,570	7,178,570	1.098636	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	11,378,764	11,378,764	1.106610	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	4,786,575	39,096,209	43,882,784	0.156511	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	325,621	1,964,298	2,289,919	0.727007	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,222,883	3,222,883			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,644,651	1,644,651			116.00
200.00		Subtotal (see instructions)	81,084,189	206,054,586	287,138,775			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	81,084,189	206,054,586	287,138,775			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/18/2020 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,291,539	0	1,291,539	7,251	178.12	30.00
31.00	INTENSIVE CARE UNIT	461,084		461,084	1,476	312.39	31.00
43.00	NURSERY	117,988		117,988	706	167.12	43.00
200.00	Total (lines 30 through 199)	1,870,611		1,870,611	9,433		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,349	418,404	30.00
31.00	INTENSIVE CARE UNIT	626	195,556	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	2,975	613,960	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	672,074	32,013,770	0.020993	3,346,563	70,254	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,360	2,338,896	0.023242	5,586	130	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,454	19,812,312	0.021272	1,149,566	24,454	54.00
57.00	05700	CT SCAN	27,328	28,952,777	0.000944	1,070,693	1,011	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,291	8,282,669	0.002691	166,104	447	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	364,469	37,421,561	0.009740	3,559,041	34,665	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	83,295	6,643,894	0.012537	1,569,750	19,680	65.00
66.00	06600	PHYSICAL THERAPY	262,646	4,990,046	0.052634	392,203	20,643	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,994	626,997	0.020724	90,394	1,873	67.00
68.00	06800	SPEECH PATHOLOGY	7,682	305,980	0.025106	58,804	1,476	68.00
69.00	06900	ELECTROCARDIOLOGY	7,336	6,725,357	0.001091	870,411	950	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,734	15,167,618	0.003938	2,061,631	8,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	186,397	23,062,253	0.008082	6,485,054	52,412	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,114	10,193,271	0.008448	2,525,076	21,332	73.00
76.00	03950	CARDIAC REHAB	20,643	757,200	0.027262	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	217,921	7,178,570	0.030357	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	461,163	11,378,764	0.040528	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	453,608	43,882,784	0.010337	1,659,328	17,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	192,902	2,289,919	0.084240	98,342	8,284	92.00
200.00		Total (lines 50 through 199)	3,614,411	262,024,638		25,108,546	282,882	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	7,251	0.00	2,349	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,476	0.00	626	31.00
43.00	04300	NURSERY		0	706	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,433		2,975	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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	32,013,770	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,338,896	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,812,312	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	28,952,777	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,282,669	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	37,421,561	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,643,894	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,990,046	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	626,997	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	305,980	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,725,357	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,167,618	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	23,062,253	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,193,271	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	757,200	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,178,570	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	11,378,764	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	43,882,784	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,289,919	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	262,024,638		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,346,563	0	5,838,791	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	5,586	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,149,566	0	5,301,599	0	54.00
57.00	05700	CT SCAN	0.000000	1,070,693	0	7,067,584	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	166,104	0	2,170,687	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	3,559,041	0	2,806,788	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	1,569,750	0	373,794	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	392,203	0	34,213	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	90,394	0	6,129	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	58,804	0	3,453	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	870,411	0	2,461,271	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,061,631	0	1,872,348	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	6,485,054	0	3,726,609	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,525,076	0	3,739,450	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	291,787	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
91.00	09100	EMERGENCY	0.000000	1,659,328	0	8,129,905	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	98,342	0	757,276	0	92.00
200.00		Total (lines 50 through 199)		25,108,546	0	44,581,684	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.252491	5,838,791	0	0	1,474,242	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.169173	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221254	5,301,599	0	0	1,173,000	54.00
57.00	05700	CT SCAN	0.026725	7,067,584	0	0	188,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054408	2,170,687	0	0	118,103	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.182841	2,806,788	0	0	513,196	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.214404	373,794	0	0	80,143	65.00
66.00	06600	PHYSICAL THERAPY	0.720466	34,213	0	0	24,649	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.613829	6,129	0	0	3,762	67.00
68.00	06800	SPEECH PATHOLOGY	0.531077	3,453	0	0	1,834	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079822	2,461,271	0	0	196,464	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142889	1,872,348	0	0	267,538	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.323865	3,726,609	0	0	1,206,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.412957	3,739,450	0	2,143	1,544,232	73.00
76.00	03950	CARDIAC REHAB	0.362841	291,787	0	0	105,872	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.156511	8,129,905	0	0	1,272,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.727007	757,276	0	0	550,545	92.00
200.00		Subtotal (see instructions)		44,581,684	0	2,143	8,721,799	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		44,581,684	0	2,143	8,721,799	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	885		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	885		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	885		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,251	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,251	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)	6,168	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,349	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,146,226	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,146,226	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)	11,146,226	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)	1,537.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,610,883	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)	3,610,883	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,636,302	1,476	2,463.62	626	1,542,226	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)	6,332,793	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,485,902	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)	613,960	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	282,882	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	896,842	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	10,589,060	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)	1,083	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,537.20	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,664,788	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,291,539	11,146,226	0.115872	1,664,788	192,902	90.00
91.00	Nursing School cost	0	11,146,226	0.000000	1,664,788	0	91.00
92.00	Allied health cost	0	11,146,226	0.000000	1,664,788	0	92.00
93.00	All other Medical Education	0	11,146,226	0.000000	1,664,788	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 5/18/2020 9:36 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,251	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,251	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)	6,168	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	187	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)	706	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,146,226	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,146,226	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)	11,146,226	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)	1,537.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	287,456	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)	287,456	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/18/2020 9:36 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,364,095	706	1,932.15	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,636,302	1,476	2,463.62	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	165,940	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	453,396	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,083	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,537.20	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,664,788	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/18/2020 9:36 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,291,539	11,146,226	0.115872	1,664,788	192,902	90.00
91.00	Nursing School cost	0	11,146,226	0.000000	1,664,788	0	91.00
92.00	Allied health cost	0	11,146,226	0.000000	1,664,788	0	92.00
93.00	All other Medical Education	0	11,146,226	0.000000	1,664,788	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,569,177		30.00
31.00	03100	INTENSIVE CARE UNIT		1,853,768		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.252491	3,346,563	844,977	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.169173	5,586	945	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221254	1,149,566	254,346	54.00
57.00	05700	CT SCAN	0.026725	1,070,693	28,614	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054408	166,104	9,037	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.182841	3,559,041	650,739	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.214404	1,569,750	336,561	65.00
66.00	06600	PHYSICAL THERAPY	0.720466	392,203	282,569	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.613829	90,394	55,486	67.00
68.00	06800	SPEECH PATHOLOGY	0.531077	58,804	31,229	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079822	870,411	69,478	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142889	2,061,631	294,584	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.323865	6,485,054	2,100,282	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.412957	2,525,076	1,042,748	73.00
76.00	03950	CARDIAC REHAB	0.362841	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.156511	1,659,328	259,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.727007	98,342	71,495	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		25,108,546	6,332,793	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)		25,108,546		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 5/18/2020 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		164,496		30.00
31.00	03100	INTENSIVE CARE UNIT		76,276		31.00
43.00	04300	NURSERY		215,161		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.252491	180,752	45,638	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.169173	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221254	25,366	5,612	54.00
57.00	05700	CT SCAN	0.026725	26,888	719	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054408	8,834	481	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.182841	148,750	27,198	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.214404	58,077	12,452	65.00
66.00	06600	PHYSICAL THERAPY	0.720466	5,797	4,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.613829	1,494	917	67.00
68.00	06800	SPEECH PATHOLOGY	0.531077	658	349	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079822	15,732	1,256	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142889	156,820	22,408	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.323865	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.412957	80,328	33,172	73.00
76.00	03950	CARDIAC REHAB	0.362841	242	88	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.098636	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.106610	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100	EMERGENCY	0.156511	73,302	11,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.727007	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		783,040	165,940	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)		783,040		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,279,339	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,861,938	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	48,018	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	44.91	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.59	31.00
32.00	Sum of lines 30 and 31	26.56	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.13	33.00
34.00	Disproportionate share adjustment (see instructions)	198,707	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	540,863	476,271	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	404,536	119,718	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	524,254		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,912,256		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	9,082,552		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	8,789,978	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	586,287	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	9,376,265	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	9,376,265	61.00
62.00	Deductibles billed to program beneficiaries	886,312	62.00
63.00	Coinsurance billed to program beneficiaries	682	63.00
64.00	Allowable bad debts (see instructions)	53,830	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	34,990	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,183	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,524,261	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	551	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-3,083	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	4,139	70.93
70.94	HRR adjustment amount (see instructions)	-25,485	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	696,307	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2020	321,660	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,518,350	71.00
71.01	Sequestration adjustment (see instructions)		190,367	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,292,856	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		35,127	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		140,610	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	656,488	221,234	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0020432057	0.9964299598	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	1,341	-790	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9981	0.9917	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-1,247	-1,836	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,279,339	0	5,279,339		5,279,339	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,861,938	0		1,861,938	1,861,938	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	48,018	0	48,018		48,018	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1113	0.1113	0.1113	0.1113		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	198,707	0	146,898	51,809	198,707	11.00
11.01	Uncompensated care payments	36.00	524,254	0	404,536	119,718	524,254	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,912,256	0	5,878,791	2,033,465	7,912,256	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,082,552	0	6,725,250	2,357,302	9,082,552	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,789,978	0	6,513,635	2,276,343	8,789,978	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	586,287	8,304	-148,444	726,427	586,287	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/18/2020 9:36 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			8,304	6,365,191	3,002,770	9,376,265	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	577,992	0	-148,444	726,436	577,992	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,295	8,304	0	-9	8,295	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	586,287	8,304	-148,444	726,427	586,287	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.109393	0.107121		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			696,307		696,307	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				321,660	321,660	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/18/2020 9:36 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,279,339	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,861,938		7,141,277	7,141,277	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	48,018	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		48,018	48,018	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1113	0.1113	0.1113		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	198,707	0	198,707	198,707	11.00
11.01	Uncompensated care payments	36.00	524,254	404,536	119,718	524,254	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,912,256	404,536	7,507,720	7,912,256	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,082,552	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,789,978	404,536	8,385,442	8,789,978	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	586,287	438,510	147,777	586,287	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			843,046	8,533,219	9,376,265	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/18/2020 9:36 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	577,992	432,306	145,686	577,992	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,295	6,204	2,091	8,295	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	586,287	438,510	147,777	586,287	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	696,307	696,307		696,307	28.00
29.00	Low volume adjustment on or after October 1	70.97	321,660		321,660	321,660	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	4,139	0	4,139	4,139	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	551	1,341	-790	551	30.01
31.00	HRR adjustment (see instructions)	70.94	-25,485	0	-25,485	-25,485	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-3,083	-1,247	-1,836	-3,083	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	885	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,721,799	2.00
3.00	OPPS payments	8,331,222	3.00
4.00	Outlier payment (see instructions)	13,688	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)	885	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,143	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	2,143	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	2,143	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,258	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)	885	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)	8,344,910	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,571,650	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)	6,774,145	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)	6,774,145	30.00
31.00	Primary payer payments	856	31.00
32.00	Subtotal (line 30 minus line 31)	6,773,289	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)	292,572	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	190,172	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	264,935	36.00
37.00	Subtotal (see instructions)	6,963,461	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-100	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)	6,963,561	40.00
40.01	Sequestration adjustment (see instructions)	139,271	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,807,594	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	16,696	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2020 9:36 am

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		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		9,292,856		6,637,933	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	12/31/2019	130,461	3.01
3.02			0	08/13/2019	39,200	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		169,661	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)		9,292,856		6,807,594	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		35,127		16,696	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,327,983		6,824,290	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: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 5/18/2020 9:36 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	453,396		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	453,396	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	453,396	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	455,933		8.00
9.00	Ancillary service charges	783,040	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,238,973	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,238,973	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	785,577	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	453,396	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	453,396	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	453,396	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	453,396	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	453,396	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	453,396	0	40.00
41.00	Interim payments	585,787	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-132,391	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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 5/18/2020 9:36 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	1,615,541	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	16,713,194	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	761,191	0	0	0	7.00
8.00	Prepaid expenses	1,296,938	0	0	0	8.00
9.00	Other current assets	6,402,199	0	0	0	9.00
10.00	Due from other funds	66,066,490	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	92,855,553	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	46,000	0	0	0	12.00
13.00	Land improvements	2,117,571	0	0	0	13.00
14.00	Accumulated depreciation	-1,522,519	0	0	0	14.00
15.00	Buildings	41,619,768	0	0	0	15.00
16.00	Accumulated depreciation	-31,410,993	0	0	0	16.00
17.00	Leasehold improvements	1,115,708	0	0	0	17.00
18.00	Accumulated depreciation	-1,082,642	0	0	0	18.00
19.00	Fixed equipment	18,029,130	0	0	0	19.00
20.00	Accumulated depreciation	-12,604,107	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	37,295,443	0	0	0	23.00
24.00	Accumulated depreciation	-21,627,111	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	31,976,248	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	11,572,692	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	7,657,980	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,230,672	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	144,062,473	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,977,083	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,702,733	0	0	0	38.00
39.00	Payroll taxes payable	1	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,659,497	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	43,321,285	0	0	0	43.00
44.00	Other current liabilities	626,189	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	54,286,788	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,951,577	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,951,577	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	67,238,365	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	76,824,108				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)	76,824,108	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	144,062,473	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 5/18/2020 9:36 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		71,132,144		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,691,961				2.00
3.00	Total (sum of line 1 and line 2)		76,824,105		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)		76,824,105		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)		76,824,105		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: 15-0030 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/18/2020 9:36 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,096,447		15,096,447	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)	15,096,447		15,096,447	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,150,156		5,150,156	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)	5,150,156		5,150,156	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,246,603		20,246,603	17.00
18.00	Ancillary services	55,725,390	141,569,211	197,294,601	18.00
19.00	Outpatient services	5,112,196	41,060,832	46,173,028	19.00
20.00	RURAL HEALTH CLINIC	0	7,178,570	7,178,570	20.00
20.01	RURAL HEALTH CLINIC II	0	11,378,764	11,378,764	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		3,222,883	3,222,883	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,644,651	1,644,651	26.00
27.00	NON-REIMBURSABLE	2,814	12,978,449	12,981,263	27.00
27.01	PRO FEES	0	9,053,302	9,053,302	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	81,087,003	228,086,662	309,173,665	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		106,208,247		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)		106,208,247		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 5/18/2020 9:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	309,173,665	1.00
2.00	Less contractual allowances and discounts on patients' accounts	204,937,675	2.00
3.00	Net patient revenues (line 1 minus line 2)	104,235,990	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	106,208,247	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,972,257	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,546,544	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	INVESTMENT INCOME	5,970,064	24.00
24.01	OTHER NONOPERATING	147,610	24.01
25.00	Total other income (sum of lines 6-24)	7,664,218	25.00
26.00	Total (line 5 plus line 25)	5,691,961	26.00
27.00	LOSS ON SALE OF EQUIPMENT	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)	5,691,961	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H Date/Time Prepared: 5/18/2020 9:36 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	121,962	0	81,793	0	275,829	479,584	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	585,978	0	0	0	0	585,978	6.00
7.00	Physical Therapy	287,462	0	0	0	0	287,462	7.00
8.00	Occupational Therapy	48,581	0	0	0	0	48,581	8.00
9.00	Speech Pathology	2,199	0	0	0	0	2,199	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	26,449	0	0	0	0	26,449	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,072,631	0	81,793	0	275,829	1,430,253	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-12,023	467,561	-15,142	452,419			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	585,978	0	585,978			6.00
7.00	Physical Therapy	0	287,462	0	287,462			7.00
8.00	Occupational Therapy	0	48,581	0	48,581			8.00
9.00	Speech Pathology	0	2,199	0	2,199			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	26,449	0	26,449			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-12,023	1,418,230	-15,142	1,403,088			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0030
HHA CCN: 15-7430

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

Worksheet H-1 Part I
Date/Time Prepared: 5/18/2020 9:36 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	452,419	0	0	0	0	452,419	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	585,978	0	0	0	0	585,978	6.00
7.00	Physical Therapy	287,462	0	0	0	0	287,462	7.00
8.00	Occupational Therapy	48,581	0	0	0	0	48,581	8.00
9.00	Speech Pathology	2,199	0	0	0	0	2,199	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	26,449	0	0	0	0	26,449	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,403,088	0	0	0	0	1,403,088	24.00

		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	452,419						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	278,865	864,843					6.00
7.00	Physical Therapy	136,802	424,264					7.00
8.00	Occupational Therapy	23,119	71,700					8.00
9.00	Speech Pathology	1,046	3,245					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	12,587	39,036					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,403,088					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-1 Part II | Date/Time Prepared: 5/18/2020 9:36 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-452,419	950,669	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	585,978	6.00
7.00	Physical Therapy	0	0	0	0	0	287,462	7.00
8.00	Occupational Therapy	0	0	0	0	0	48,581	8.00
9.00	Speech Pathology	0	0	0	0	0	2,199	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	26,449	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-452,419	950,669	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		452,419	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.475895	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030
HHA CCN: 15-7430

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

Worksheet H-2 Part I
Date/Time Prepared: 5/18/2020 9:36 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	388,427	388,427	78,792	1.00
2.00	Skilled Nursing Care	864,843	0	0	0	864,843	175,433	2.00
3.00	Physical Therapy	424,264	0	0	0	424,264	86,062	3.00
4.00	Occupational Therapy	71,700	0	0	0	71,700	14,544	4.00
5.00	Speech Pathology	3,245	0	0	0	3,245	658	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	39,036	0	0	0	39,036	7,918	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,403,088	0	0	388,427	1,791,515	363,407	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	62,549	0	9,540	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	62,549	0	9,540	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part I Date/Time Prepared: 5/18/2020 9:36 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	5,664	0	5,729	550,701	0	550,701	1.00
2.00	Skilled Nursing Care	0	0	0	1,040,276	0	1,040,276	2.00
3.00	Physical Therapy	0	0	0	510,326	0	510,326	3.00
4.00	Occupational Therapy	0	0	0	86,244	0	86,244	4.00
5.00	Speech Pathology	0	0	0	3,903	0	3,903	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	46,954	0	46,954	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	5,664	0	5,729	2,238,404	0	2,238,404	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	339,444	1,379,720					2.00
3.00	Physical Therapy	166,520	676,846					3.00
4.00	Occupational Therapy	28,142	114,386					4.00
5.00	Speech Pathology	1,274	5,177					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	15,321	62,275					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	550,701	2,238,404					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.326302						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part II | Date/Time Prepared: 5/18/2020 9:36 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	0	1,072,631	0	388,427	2,290	1.00
2.00	Skilled Nursing Care	0	0	0	0	864,843	0	2.00
3.00	Physical Therapy	0	0	0	0	424,264	0	3.00
4.00	Occupational Therapy	0	0	0	0	71,700	0	4.00
5.00	Speech Pathology	0	0	0	0	3,245	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	39,036	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	1,072,631		1,791,515	2,290	20.00
21.00	Total cost to be allocated	0	0	388,427		363,407	62,549	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.362125		0.202849	27.313974	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	40	0	0	0	34,817	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	40	0	0	0	34,817	20.00
21.00	Total cost to be allocated	0	9,540	0	0	0	5,664	21.00
22.00	Unit cost multiplier	0.000000	238.500000	0.000000	0.000000	0.000000	0.162679	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 HHA CCN: 15-7430

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

Worksheet H-2 Part II Date/Time Prepared: 5/18/2020 9:36 am

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	0	15			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	15			20.00
21.00	Total cost to be allocated	0	5,729			21.00
22.00	Unit cost multiplier	0.000000	381.933333			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part I | Date/Time Prepared: 5/18/2020 9:36 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,379,720		1,379,720	4,466	308.94	1.00
2.00	Physical Therapy	3.00	676,846	0	676,846	4,975	136.05	2.00
3.00	Occupational Therapy	4.00	114,386	0	114,386	353	324.04	3.00
4.00	Speech Pathology	5.00	5,177	0	5,177	50	103.54	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	62,275		62,275	887	70.21	6.00
7.00	Total (sum of lines 1-6)		2,238,404	0	2,238,404	10,731		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		17140	0	6			8.00
8.01	Skilled Nursing Care		26900	0	68			8.01
8.02	Skilled Nursing Care		34620	0	39			8.02
8.03	Skilled Nursing Care		99915	0	1,861			8.03
9.00	Physical Therapy		17140	0	12			9.00
9.01	Physical Therapy		26900	0	21			9.01
9.02	Physical Therapy		34620	0	70			9.02
9.03	Physical Therapy		99915	0	2,047			9.03
10.00	Occupational Therapy		17140	0	0			10.00
10.01	Occupational Therapy		26900	0	2			10.01
10.02	Occupational Therapy		34620	0	0			10.02
10.03	Occupational Therapy		99915	0	151			10.03
11.00	Speech Pathology		17140	0	0			11.00
11.01	Speech Pathology		26900	0	0			11.01
11.02	Speech Pathology		34620	0	0			11.02
11.03	Speech Pathology		99915	0	39			11.03
12.00	Medical Social Services		17140	0	0			12.00
12.01	Medical Social Services		26900	0	0			12.01
12.02	Medical Social Services		34620	0	0			12.02
12.03	Medical Social Services		99915	0	0			12.03
13.00	Home Health Aide		17140	0	0			13.00
13.01	Home Health Aide		26900	0	26			13.01
13.02	Home Health Aide		34620	0	16			13.02
13.03	Home Health Aide		99915	0	264			13.03
14.00	Total (sum of lines 8-13)			0	4,622			14.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part I Date/Time Prepared: 5/18/2020 9:36 am

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	Cost Center Description	Program Visits			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,974		0	609,848		1.00
2.00	Physical Therapy	0	2,150		0	292,508		2.00
3.00	Occupational Therapy	0	153		0	49,578		3.00
4.00	Speech Pathology	0	39		0	4,038		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	306		0	21,484		6.00
7.00	Total (sum of lines 1-6)	0	4,622		0	977,456		7.00
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	3,814	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part I Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	609,848		1.00
2.00	Physical Therapy	292,508		2.00
3.00	Occupational Therapy	49,578		3.00
4.00	Speech Pathology	4,038		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	21,484		6.00
7.00	Total (sum of lines 1-6)	977,456		7.00
	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part II Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.720466	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.613829	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.531077	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.142889	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.412957	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	789,824	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	22,826	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	10,705	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	691	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	4,386	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	828,432	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	828,432	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	828,432	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	828,432	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	828,432	31.00
31.01	Sequestration adjustment (see instructions)	0	16,568	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	811,863	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-5 | Date/Time Prepared: 5/18/2020 9:36 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		811,863	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		811,863	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		811,864	7.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O | Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	4,770	4,770	-4,770	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	76,752	279,672	356,424	0	356,424	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	53,989	53,989	0	53,989	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	227	227	0	227	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	4,244	4,244	0	4,244	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		6,443	6,443	0	6,443	25.00
26.00	PHYSICIAN SERVICES**	27,301	0	27,301	0	27,301	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	258,247	0	258,247	0	258,247	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	25	0	25	0	25	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	35,358	0	35,358	0	35,358	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	24,539	0	24,539	0	24,539	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	422,222	349,345	771,567	-4,770	766,797	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O | Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	-14,555	-14,555		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	356,424		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	53,989		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	227		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	4,244		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	6,443		25.00
26.00	PHYSICIAN SERVICES**	0	27,301		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	258,247		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	25		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	35,358		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	24,539		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-14,555	752,242		100.00

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

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

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-2 | Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	27,032	0	27,032	0	27,032	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	255,710	0	255,710	0	255,710	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	25	0	25	0	25	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	35,010	0	35,010	0	35,010	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	24,298	0	24,298	0	24,298	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	342,075	0	342,075	0	342,075	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	27,032		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	255,710		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	25		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	35,010		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	24,298		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	342,075		100.00

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

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

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-3 | Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		3,929	3,929	0	3,929	25.00
26.00	PHYSICIAN SERVICES	164	0	164	0	164	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,547	0	1,547	0	1,547	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	212	0	212	0	212	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	147	0	147	0	147	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	2,070	3,929	5,999	0	5,999	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	3,929		25.00
26.00	PHYSICIAN SERVICES	0	164		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,547		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	212		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	147		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	5,999		100.00

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

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

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-4 | Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		2,514	2,514	0	2,514	25.00
26.00	PHYSICIAN SERVICES	105	0	105	0	105	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	990	0	990	0	990	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	136	0	136	0	136	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	94	0	94	0	94	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,325	2,514	3,839	0	3,839	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	2,514		25.00
26.00	PHYSICIAN SERVICES	0	105		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	990		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	136		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	94		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	3,839		100.00

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

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

Provider CCN: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-5

Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	152,897	152,897	3.00
4.00	ADMINISTRATIVE & GENERAL	356,424	183,607	540,031	4.00
5.00	PLANT OPERATION & MAINTENANCE	53,989	62,522	116,511	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	227	2,071	2,298	10.00
11.00	MEDICAL RECORDS	0	3,056	3,056	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	4,244	0	4,244	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	342,075		342,075	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5,999		5,999	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,839		3,839	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	-14,555		-14,555	99.00
100.00	TOTAL	752,242	404,153	1,156,395	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part I
Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	152,897	0	0	152,897		3.00
4.00	ADMINISTRATIVE & GENERAL	540,031	0	0	0	540,031	4.00
5.00	PLANT OPERATION & MAINTENANCE	116,511	0	0	0	116,511	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,298	0	0	0	2,298	10.00
11.00	MEDICAL RECORDS	3,056	0	0	0	3,056	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	4,244	0	0	0	4,244	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	342,075			151,395	493,470	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5,999	0	0	916	6,915	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,839	0	0	586	4,425	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	-14,555	0	0	0		99.00
100.00	TOTAL	1,156,395	0	0	152,897	1,156,395	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-6 Part I Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	540,031					4.00
5.00	PLANT OPERATION & MAINTENANCE	99,727	216,238				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,967	0		0		10.00
11.00	MEDICAL RECORDS	2,616	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	3,633	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	422,381					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5,919	131,852	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,788	84,386	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	540,031	216,238	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part I
Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	4,265				10.00
11.00	MEDICAL RECORDS	0		5,672			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	4,223	5,616	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	26	34	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	16	22	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	4,265	5,672	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part I
Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	7,877					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	7,799	0	0		933,489	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	48	0	0	0	144,794	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	30	0	0	0	92,667	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	-14,555	99.00
100.00	TOTAL	7,877	0	0	0	1,156,395	100.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
5/18/2020 9:36 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	129,721			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-540,031	630,919	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	116,511	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	2,298	10.00
11.00	MEDICAL RECORDS	0	0	0	0	3,056	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	4,244	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			128,447	0	493,470	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	777	0	6,915	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	497	0	4,425	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	152,897		540,031	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	1.178660		0.855943	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
5/18/2020 9:36 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	247,821					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	151,110	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	96,711	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	216,238	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.872557	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
5/18/2020 9:36 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,174					10.00
11.00	MEDICAL RECORDS		4,174				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	9,112	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4,133	4,133	0	0	9,022	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	25	25	0	0	55	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	16	16	0	0	35	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	4,265	5,672	0	0	7,877	100.00
101.00	UNIT COST MULTIPLIER	1.021802	1.358888	0.000000	0.000000	0.864464	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
5/18/2020 9:36 am

Hospice I

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

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

Provider CCN: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-7

Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.720466	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.613829	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.531077	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.412957	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.182841	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.142889	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CARDIAC REHAB	76.00	0.362841	0	0	0	10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	CARDIAC REHAB	0	0	0	0	0	10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-8 | Date/Time Prepared: 5/18/2020 9:36 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			933,489	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			4,133	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			225.86	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,167	36		9.00
10.00	Program cost (line 8 times line 9)	715,299	8,131		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			144,794	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			25	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			5,791.76	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	21	0		14.00
15.00	Program cost (line 13 times line 14)	121,627	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			92,667	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			16	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			5,791.69	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	14	2		19.00
20.00	Program cost (line 18 times line 19)	81,084	11,583		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,170,950	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			4,174	22.00
23.00	Average cost per diem (line 21 divided by line 22)			280.53	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0030	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	577,992	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	8,295	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	21.05	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	586,287	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 5/18/2020 9:36 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,287,154	22,077	1,309,231	0	1,309,231	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	655,376	0	655,376	15,146	670,522	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	377,413	0	377,413	0	377,413	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	49,402	0	49,402	0	49,402	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	435,119	0	435,119	0	435,119	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,804,464	22,077	2,826,541	15,146	2,841,687	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	177,992	177,992	0	177,992	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	43,293	43,293	0	43,293	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	221,285	221,285	0	221,285	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,804,464	243,362	3,047,826	15,146	3,062,972	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	575,784	575,784	0	575,784	29.00
30.00	Administrative Costs	809,556	921,163	1,730,719	-714,526	1,016,193	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	809,556	1,496,947	2,306,503	-714,526	1,591,977	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,614,020	1,740,309	5,354,329	-699,380	4,654,949	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 5/18/2020 9:36 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,309,231		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	670,522		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	377,413		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	49,402		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	435,119		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,841,687		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	177,992		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	43,293		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	221,285		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,062,972		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-275,459	300,325		29.00
30.00	Administrative Costs	-144,344	871,849		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-419,803	1,172,174		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-419,803	4,235,146		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 5/18/2020 9:36 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,493,255	52,900	2,546,155	-1,122,773	1,423,382	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,505,667	0	1,505,667	103,575	1,609,242	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	399,223	0	399,223	0	399,223	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	62,974	51,747	114,721	0	114,721	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	698,249	0	698,249	0	698,249	9.00
10.00	Subtotal (sum of lines 1 through 9)	5,159,368	104,647	5,264,015	-1,019,198	4,244,817	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	452,775	452,775	0	452,775	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	452,775	452,775	0	452,775	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,159,368	557,422	5,716,790	-1,019,198	4,697,592	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,337,589	1,337,589	0	1,337,589	29.00
30.00	Administrative Costs	668,135	1,312,892	1,981,027	-831,148	1,149,879	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	668,135	2,650,481	3,318,616	-831,148	2,487,468	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,827,503	3,207,903	9,035,406	-1,850,346	7,185,060	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 5/18/2020 9:36 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,423,382		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1,609,242		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	399,223		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	114,721		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	698,249		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,244,817		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	452,775		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	452,775		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	4,697,592		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-673,316	664,273		29.00
30.00	Administrative Costs	-114,750	1,035,129		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-788,066	1,699,402		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-788,066	6,396,994		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 5/18/2020 9:36 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.23	17,902	4,200	17,766		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.15	8,771	2,100	8,715		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.38	26,673		26,481	26,673	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.48	299			299	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.86	26,972			26,972	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,062,972	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,062,972	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,172,174	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,651,487	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,823,661	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,823,661	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,823,661	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,886,633	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 5/18/2020 9:36 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	5.35	20,309	4,200	22,470		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	10.72	23,276	2,100	22,512		3.00
4.00	Subtotal (sum of lines 1 through 3)	16.07	43,585		44,982	44,982	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.59	1,394			1,394	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	16.66	44,979			46,376	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					4,697,592	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,697,592	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,699,402	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					6,194,859	15.00
16.00	Total overhead (sum of lines 14 and 15)					7,894,261	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					7,894,261	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					7,894,261	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					12,591,853	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		7,886,633	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		350,396	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		7,536,237	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		26,972	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		26,972	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		279.41	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	279.41	279.41	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	8,070	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,254,839	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	2,254,839	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,388,341	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		331,100	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		537,748	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,263,006	16.04
16.05	Total program cost (see instructions)	0	1,800,754	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		138,333	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		183,782	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,800,754	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		154,626	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,955,380	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		1,955,380	26.00
26.01	Sequestration adjustment (see instructions)		39,108	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,641,207	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		275,065	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			12,591,853	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			809,118	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			11,782,735	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			46,376	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			46,376	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			254.07	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	254.07	254.07		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,556		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,411,613		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,411,613		16.00
16.01	Total program charges (see instructions)(from contractor's records)		919,313		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		171,553		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		263,421		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		839,538		16.04
16.05	Total program cost (see instructions)	0	1,102,959		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		98,770		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		129,784		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,102,959		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		86,140		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,189,099		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,189,099		26.00
26.01	Sequestration adjustment (see instructions)		23,782		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,119,338		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		45,979		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 5/18/2020 9:36 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,841,687	2,841,687	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001466	0.005952	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,166	16,914	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	62,167	52,839	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	66,333	69,753	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,062,972	3,062,972	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,823,661	4,823,661	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.021656	0.022773	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	104,461	109,849	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	170,794	179,602	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	506	2,054	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	337.54	87.44	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	255	784	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	86,073	68,553	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		350,396	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		154,626	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-4 | Date/Time Prepared: 5/18/2020 9:36 am

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4,244,817	4,244,817	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003363	0.004143	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	14,275	17,586	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	214,636	55,360	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	228,911	72,946	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	4,697,592	4,697,592	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	7,894,261	7,894,261	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.048729	0.015528	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	384,679	122,582	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	613,590	195,528	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,747	2,152	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	351.22	90.86	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	126	461	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	44,254	41,886	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		809,118	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		86,140	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 5/18/2020 9:36 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,499,807	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	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		08/31/2019	141,400	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		141,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,641,207	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		275,065	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,916,272	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-5 | Date/Time Prepared: 5/18/2020 9:36 am

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		959,538	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	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		08/31/2019	159,800	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		159,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,119,338	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		45,979	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,165,317	7.00

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