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: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 9:00 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/29/2020 Time: 9:00 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) 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) MICHAEL CRAIG
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	-29,830	459,703	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-29,830	459,703	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 9:00 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 WEST SIXTEENTH STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421-	County: LAWRENCE	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	INDIANA UNIVERSITY HEALTH BEDFORD	151328	99915	1	10/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH BEDFORD - SWING BED	15Z328	99915		10/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 9:00 am

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

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 9:00 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	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.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 9:00 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	65,930	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 9:00 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: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

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

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

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	136	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 9:00 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2020	Y	04/01/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 9:00 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 9:00 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.	DIRECTOR		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: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 6/29/2020 9:00 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	19	6,935	73,272.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		19	6,935	73,272.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	26,736.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	100,008.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 9:00 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,593	66	3,053			1.00
2.00	HMO and other (see instructions)	716	366				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	11			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,593	66	3,064			7.00
8.00	INTENSIVE CARE UNIT	557	29	1,114			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)	2,150	95	4,178	0.00	223.53	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			10			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	223.53	27.00
28.00	Observation Bed Days		25	1,325			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 9:00 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	694	25	1,356	1.00
2.00	HMO and other (see instructions)			215	135		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	694	25	1,356	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 6/29/2020 9:00 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)	0.223622	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,988,360	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	35,917,785	6.00
7.00	Medicaid cost (line 1 times line 6)	8,032,007	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,043,647	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,043,647	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)	4,593,103	180,886	4,773,989	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,027,119	180,886	1,208,005	21.00
22.00	Payments received from patients for amounts previously written off as charity care	7,735	0	7,735	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,019,384	180,886	1,200,270	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)	7,791,714	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,626,300	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,502,000	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,289,714	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,058,596	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,258,866	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,302,513	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	550,166	550,166	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,129,006	1,129,006	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	82,929	234,887	317,816	2,443,398	2,761,214	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	469,294	14,487,742	14,957,036	-292,403	14,664,633	5.00
7.00	00700	OPERATION OF PLANT	603,861	1,983,562	2,587,423	-440,660	2,146,763	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	128,108	128,108	-1,266	126,842	8.00
9.00	00900	HOUSEKEEPING	386,432	336,678	723,110	-136,521	586,589	9.00
10.00	01000	DIETARY	391,566	270,687	662,253	-198,661	463,592	10.00
11.00	01100	CAFETERIA	0	0	0	129,466	129,466	11.00
13.00	01300	NURSING ADMINISTRATION	1,545,948	2,062,277	3,608,225	-274,537	3,333,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,629	110,828	163,457	1,063,950	1,227,407	14.00
15.00	01500	PHARMACY	477,667	12,417,170	12,894,837	-11,891,552	1,003,285	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	46,045	46,045	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,005,359	1,837,171	3,842,530	-530,444	3,312,086	30.00
31.00	03100	INTENSIVE CARE UNIT	972,700	669,903	1,642,603	-304,232	1,338,371	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,116,548	1,553,962	2,670,510	-859,432	1,811,078	50.00
51.00	05100	RECOVERY ROOM	321,874	85,809	407,683	-58,755	348,928	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,001,514	861,048	1,862,562	-521,067	1,341,495	54.00
56.00	05600	RADIOISOTOPE	80,724	274,861	355,585	-177,412	178,173	56.00
57.00	05700	CT SCAN	307,676	353,185	660,861	-236,660	424,201	57.00
58.00	05800	MRI	144,998	191,871	336,869	-52,565	284,304	58.00
60.00	06000	LABORATORY	286,934	3,361,246	3,648,180	-25,278	3,622,902	60.00
65.00	06500	RESPIRATORY THERAPY	664,439	283,799	948,238	-228,844	719,394	65.00
66.00	06600	PHYSICAL THERAPY	626,777	178,654	805,431	-123,720	681,711	66.00
67.00	06700	OCCUPATIONAL THERAPY	332,272	81,634	413,906	-50,777	363,129	67.00
68.00	06800	SPEECH PATHOLOGY	68,797	19,885	88,682	-16,575	72,107	68.00
69.00	06900	ELECTROCARDIOLOGY	333,936	619,271	953,207	-215,925	737,282	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	190,769	190,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	139,035	139,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,916,134	11,916,134	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	72,025	72,025	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	836,511	354,226	1,190,737	-198,098	992,639	90.00
90.01	09001	CLINIC - DIABETES	38,197	55,217	93,414	-195	93,219	90.01
91.00	09100	EMERGENCY	1,669,673	1,580,817	3,250,490	-522,646	2,727,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,819,255	44,394,498	59,213,753	321,769	59,535,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,099	6,341	21,440	-5,261	16,179	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	267,490	267,490	-267,453	37	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	17,223	17,223	-320	16,903	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	156,488	64,201	220,689	-48,694	171,995	194.02
194.03	07953	HOME CARE	0	41	41	-41	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	14,990,842	44,749,794	59,740,636	0	59,740,636	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	150,735	700,901	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	302,405	1,431,411	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	795,519	3,556,733	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,303,596	12,361,037	5.00
7.00	00700	OPERATION OF PLANT	-54,631	2,092,132	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,122	125,720	8.00
9.00	00900	HOUSEKEEPING	-4,632	581,957	9.00
10.00	01000	DIETARY	24,812	488,404	10.00
11.00	01100	CAFETERIA	-110,906	18,560	11.00
13.00	01300	NURSING ADMINISTRATION	-1,526,229	1,807,459	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1	1,227,406	14.00
15.00	01500	PHARMACY	18,008	1,021,293	15.00
17.00	01700	SOCIAL SERVICE	0	46,045	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-885,573	2,426,513	30.00
31.00	03100	INTENSIVE CARE UNIT	-221,393	1,116,978	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-775,614	1,035,464	50.00
51.00	05100	RECOVERY ROOM	0	348,928	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,793	1,332,702	54.00
56.00	05600	RADIOISOTOPE	-8,127	170,046	56.00
57.00	05700	CT SCAN	0	424,201	57.00
58.00	05800	MRI	0	284,304	58.00
60.00	06000	LABORATORY	-265,148	3,357,754	60.00
65.00	06500	RESPIRATORY THERAPY	-58,557	660,837	65.00
66.00	06600	PHYSICAL THERAPY	61,470	743,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	363,129	67.00
68.00	06800	SPEECH PATHOLOGY	0	72,107	68.00
69.00	06900	ELECTROCARDIOLOGY	-3,475	733,807	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	190,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	139,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,916,134	73.00
76.97	07697	CARDIAC REHABILITATION	0	72,025	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	992,639	90.00
90.01	09001	CLINIC - DIABETES	38,070	131,289	90.01
91.00	09100	EMERGENCY	-298,989	2,428,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,135,767	54,399,755	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,179	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	16,903	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	171,995	194.02
194.03	07953	HOME CARE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,135,767	54,604,869	200.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 9:00 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,500,724	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	2,500,724	
	B - DIETARY/CAFETERIA				
1.00	CAFETERIA	11.00	66,033	63,433	1.00
	0		66,033	63,433	
	C - CAPITAL LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,432	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,047	2.00
	0		0	10,479	
	D - CARDIOLOGY				
1.00	CARDIAC REHABILITATION	76.97	63,281	8,744	1.00
	0		63,281	8,744	
	E - DEPR EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	499,433	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,117,173	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	0		0	1,616,606	
	F - DRUGS				
1.00	PHARMACY	15.00	0	18,273	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,916,134	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

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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	11,934,407	
	G - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	139,035	1.00
	0		0	139,035	
	H - ACCRUED PTO				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,338	1.00
2.00	HOUSEKEEPING	9.00	0	8,119	2.00
3.00	DIETARY	10.00	0	2,136	3.00
4.00	NURSING ADMINISTRATION	13.00	0	17,910	4.00
5.00	PHARMACY	15.00	0	4,356	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	28,274	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	10,160	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,062	8.00
9.00	RADIOISOTOPE	56.00	0	272	9.00
10.00	CT SCAN	57.00	0	1,753	10.00
11.00	MRI	58.00	0	910	11.00
12.00	RESPIRATORY THERAPY	65.00	0	1,900	12.00
13.00	PHYSICAL THERAPY	66.00	0	687	13.00
14.00	CLINIC	90.00	0	3,916	14.00
15.00	EMERGENCY	91.00	0	1,625	15.00
16.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	51	16.00
17.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	969	17.00
	0		0	87,438	
	I - MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,112,755	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	190,769	2.00
3.00	OPERATION OF PLANT	7.00	0	645	3.00
4.00	NURSING ADMINISTRATION	13.00	0	460	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	0		0	1,304,630	
	J - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,301	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,786	2.00
	0		0	52,087	
	L - SOCIAL WORKER				
1.00	SOCIAL SERVICE	17.00	46,045	0	1.00
	0		46,045	0	
	M - CLINICAL ENGINEERING				
1.00	OPERATING ROOM	50.00	0	153,991	1.00
	TOTALS		0	153,991	
500.00	Grand Total: Increases		175,359	17,871,574	500.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 9:00 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,828	0		1.00
2.00	OPERATION OF PLANT	7.00	0	113,252	0		2.00
3.00	HOUSEKEEPING	9.00	0	110,520	0		3.00
4.00	DIETARY	10.00	0	55,102	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	240,069	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	25,064	0		6.00
7.00	PHARMACY	15.00	0	65,452	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	391,598	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	155,661	0		9.00
10.00	OPERATING ROOM	50.00	0	151,883	0		10.00
11.00	RECOVERY ROOM	51.00	0	58,174	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	207,391	0		12.00
13.00	RADIOISOTOPE	56.00	0	14,896	0		13.00
14.00	CT SCAN	57.00	0	37,627	0		14.00
15.00	MRI	58.00	0	6,170	0		15.00
16.00	LABORATORY	60.00	0	24,969	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	107,939	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	108,468	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	48,862	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	14,468	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	36,480	0		21.00
22.00	CLINIC	90.00	0	131,443	0		22.00
23.00	EMERGENCY	91.00	0	267,093	0		23.00
24.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	5,312	0		24.00
25.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	41,003	0		25.00
	0		0	2,500,724			
	B - DIETARY/CAFETERIA						
1.00	DIETARY	10.00	66,033	63,433	0		1.00
	0		66,033	63,433			
	C - CAPITAL LEASE						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10,479	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	10,479			
	D - CARDIOLOGY						
1.00	ELECTROCARDIOLOGY	69.00	63,281	8,744	0		1.00
	0		63,281	8,744			
	E - DEPR EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,727	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	160,896	9		2.00
3.00	OPERATION OF PLANT	7.00	0	163,181	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1,266	0		4.00
5.00	HOUSEKEEPING	9.00	0	1,216	0		5.00
6.00	DIETARY	10.00	0	14,868	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	6,793	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	21,057	0		8.00
9.00	PHARMACY	15.00	0	34,951	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	31,931	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	91,987	0		11.00
12.00	OPERATING ROOM	50.00	0	170,980	0		12.00
13.00	RECOVERY ROOM	51.00	0	265	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	260,313	0		14.00
15.00	RADIOISOTOPE	56.00	0	86,934	0		15.00
16.00	CT SCAN	57.00	0	103,397	0		16.00
17.00	MRI	58.00	0	26,567	0		17.00
18.00	LABORATORY	60.00	0	309	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	16,613	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	7,258	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	61,235	0		21.00
22.00	CLINIC	90.00	0	2,150	0		22.00
23.00	CLINIC - DIABETES	90.01	0	194	0		23.00
24.00	EMERGENCY	91.00	0	84,774	0		24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	256,975	0		25.00
26.00	OCCUPATIONAL HEALTH	194.00	0	272	0		26.00
27.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	8,456	0		27.00
28.00	HOME CARE	194.03	0	41	0		28.00
	0		0	1,616,606			
	F - DRUGS						
1.00	PHARMACY	15.00	0	11,780,010	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	29	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3,716	0		3.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 9:00 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
4.00	INTENSIVE CARE UNIT	31.00	0	1,900	0	4.00
5.00	OPERATING ROOM	50.00	0	1,369	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,900	0	6.00
7.00	RADIOISOTOPE	56.00	0	71,653	0	7.00
8.00	CT SCAN	57.00	0	45,251	0	8.00
9.00	MRI	58.00	0	18,841	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	433	0	10.00
11.00	CLINIC	90.00	0	3,328	0	11.00
12.00	EMERGENCY	91.00	0	2,977	0	12.00
	0		0	11,934,407		
	G - IMPLANT SUPPLIES					
1.00	OPERATING ROOM	50.00	0	139,035	0	1.00
	0		0	139,035		
	H - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	55,599	0	1.00
2.00	OPERATION OF PLANT	7.00	0	10,881	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,444	0	3.00
4.00	OPERATING ROOM	50.00	0	9,030	0	4.00
5.00	RECOVERY ROOM	51.00	0	316	0	5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	1,915	0	6.00
7.00	SPEECH PATHOLOGY	68.00	0	2,107	0	7.00
8.00	ELECTROCARDIOLOGY	69.00	0	6,146	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
	0		0	87,438		
	I - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,211	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	930	0	2.00
3.00	HOUSEKEEPING	9.00	0	32,904	0	3.00
4.00	DIETARY	10.00	0	1,361	0	4.00
5.00	PHARMACY	15.00	0	33,768	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	131,473	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	64,844	0	7.00
8.00	OPERATING ROOM	50.00	0	541,126	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	49,525	0	9.00
10.00	RADIOISOTOPE	56.00	0	4,201	0	10.00
11.00	CT SCAN	57.00	0	52,138	0	11.00
12.00	MRI	58.00	0	1,897	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	105,759	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	8,681	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	40,039	0	15.00
16.00	CLINIC	90.00	0	65,093	0	16.00
17.00	CLINIC - DIABETES	90.01	0	1	0	17.00
18.00	EMERGENCY	91.00	0	169,427	0	18.00
19.00	OCCUPATIONAL HEALTH	194.00	0	48	0	19.00
20.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	204	0	20.00
	0		0	1,304,630		
	J - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,087	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	52,087		
	L - SOCIAL WORKER					
1.00	NURSING ADMINISTRATION	13.00	46,045	0	0	1.00
	0		46,045	0		
	M - CLINICAL ENGINEERING					
1.00	OPERATION OF PLANT	7.00	0	153,991	0	1.00
	TOTALS		0	153,991		
500.00	Grand Total: Decreases		175,359	17,871,574		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I Date/Time Prepared: 6/29/2020 9:00 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	931,334	0	0	0	0	1.00
2.00	Land Improvements	1,119,735	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,929,250	0	0	0	639,150	3.00
4.00	Building Improvements	5,214,524	9,021	0	9,021	54,436	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,250,874	2,248,406	0	2,248,406	2,106,146	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,445,717	2,257,427	0	2,257,427	2,799,732	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,445,717	2,257,427	0	2,257,427	2,799,732	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	931,334	0	1.00
2.00	Land Improvements	1,119,735	0	2.00
3.00	Buildings and Fixtures	14,290,100	0	3.00
4.00	Building Improvements	5,169,109	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	15,393,134	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,903,412	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	36,903,412	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II Date/Time Prepared: 6/29/2020 9:00 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 6/29/2020 9:00 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,510,278	0	21,510,278	0.582880	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,393,136	0	15,393,136	0.417120	0	2.00
3.00	Total (sum of lines 1-2)	36,903,414	0	36,903,414	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	499,425	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,419,578	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,919,003	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	CAP REL COSTS-BLDG & FIXT	159,175	42,301	0	0	700,901	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,047	9,786	0	0	1,431,411	2.00
3.00	Total (sum of lines 1-2)	161,222	52,087	0	0	2,132,312	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 9:00 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,173,566	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,158,637			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	7,213,092			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-118,422	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-16,776	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 9:00 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	
34.00	MISCELLANEOUS INCOME	B	-224	OPERATION OF PLANT	7.00	0	34.00
35.00	MISCELLANEOUS INCOME	B	-1,122	LAUNDRY & LINEN SERVICE	8.00	0	35.00
36.00	MISCELLANEOUS INCOME	B	-3,833	HOUSEKEEPING	9.00	0	36.00
37.00	MISCELLANEOUS INCOME	B	-110,906	CAFETERIA	11.00	0	37.00
38.00	MISCELLANEOUS INCOME	B	-30,949	NURSING ADMINISTRATION	13.00	0	38.00
39.00	MISCELLANEOUS INCOME	B	-8,793	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
40.00	MISCELLANEOUS INCOME	B	-8,127	RADIOISOTOPE	56.00	0	40.00
40.01	MISCELLANEOUS INCOME	B	-58,557	RESPIRATORY THERAPY	65.00	0	40.01
41.00	MISCELLANEOUS INCOME	B	-3,466	ELECTROCARDIOLOGY	69.00	0	41.00
45.00	INVESTMENT FEES	B	6,055	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	PHONES	A	-8	CAP REL COSTS-BLDG & FIXT	1.00	9	45.01
45.02	PHONES	A	-2,935	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.02
45.03	PHONES	A	-5,200	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PHONES	A	-21,271	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	PHONES	A	-1	CENTRAL SERVICES & SUPPLY	14.00	0	45.05
45.06	HAF	A	-3,054,634	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	CABLE	A	-365	OPERATION OF PLANT	7.00	0	45.07
45.08	CABLE	A	-1,817	PHYSICAL THERAPY	66.00	0	45.08
45.09	RECRUITING	A	-27,580	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	BENEFITS	A	-2,499,281	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.10
45.11	ACCRUED PTO	A	-27,331	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.11
45.12	TELEPHONE EQUIPMENT	A	-799	HOUSEKEEPING	9.00	0	45.12
45.13	MARKETING	A	-19,407	ADMINISTRATIVE & GENERAL	5.00	0	45.13
45.14	MARKETING	A	-9	ELECTROCARDIOLOGY	69.00	0	45.14
45.17	TELEPHONE EQUIPMENT	A	-898	NURSING ADMINISTRATION	13.00	0	45.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,135,767				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 9:00 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1,324,309	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	423,762	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,401,683	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	9,074,964	8,689,638	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	152,380	226,732	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	2,222,046	1,632,496	4.02
4.03	7.00	OPERATION OF PLANT	RELATED PARTY	0	54,042	4.03
4.04	10.00	DIETARY	RELATED PARTY	24,812	0	4.04
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	95,073	1,589,455	4.05
4.06	15.00	PHARMACY	RELATED PARTY	509,999	491,991	4.06
4.07	66.00	PHYSICAL THERAPY	RELATED PARTY	63,287	0	4.07
4.08	90.01	CLINIC - DIABETES	RELATED PARTY	92,216	54,146	4.08
4.09	91.00	EMERGENCY	EMERGENCY ROOM	3,372,154	805,093	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	4,720	4,720	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	150,859	150,859	4.11
4.12	10.00	DIETARY	SHARED EMPLOYEES	19,691	19,691	4.12
4.13	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	1,100,518	1,100,518	4.13
4.14	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES	275,129	275,129	4.14
4.15	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	30,543	30,543	4.15
4.16	60.00	LABORATORY	SHARED EMPLOYEES	3,143,946	3,143,946	4.16
4.17	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	431,629	431,629	4.17
4.18	90.00	CLINIC	SHARED EMPLOYEES	53,067	53,067	4.18
4.19	90.01	CLINIC - DIABETES	SHARED EMPLOYEES	38,197	38,197	4.19
4.20	91.00	EMERGENCY	SHARED EMPLOYEES	12,000	12,000	4.20
4.21	194.00	OCCUPATIONAL HEALTH	SHARED EMPLOYEES	1,204	1,204	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			26,018,188	18,805,096	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	IU HEALTH, INC.	50.00	6.00
7.00	F		0.00	IUH BLOOMINGTO	50.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/29/2020 9:00 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	1,324,309	11	1.00
2.00	423,762	9	2.00
3.00	3,401,683	0	3.00
4.00	385,326	0	4.00
4.01	-74,352	0	4.01
4.02	589,550	0	4.02
4.03	-54,042	0	4.03
4.04	24,812	0	4.04
4.05	-1,494,382	0	4.05
4.06	18,008	0	4.06
4.07	63,287	0	4.07
4.08	38,070	0	4.08
4.09	2,567,061	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	0	0	4.14
4.15	0	0	4.15
4.16	0	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.19	0	0	4.19
4.20	0	0	4.20
4.21	0	0	4.21
5.00	7,213,092		5.00

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

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

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

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

6.00	HOME OFFICE	6.00
7.00	HEALTHCARE	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: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/29/2020 9:00 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	5.00	ADMINISTRATIVE & GENERAL	144,859	144,859	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,100,518	885,573	214,945	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	275,129	221,393	53,736	0	0	3.00
4.00	50.00	OPERATING ROOM	775,614	775,614	0	0	0	4.00
5.00	60.00	LABORATORY	286,934	265,148	21,786	0	0	5.00
6.00	91.00	EMERGENCY	3,154,128	2,866,050	288,078	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			5,737,182	5,158,637	578,545		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	144,859	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	885,573	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	221,393	3.00
4.00	50.00	OPERATING ROOM	0	0	0	775,614	4.00
5.00	60.00	LABORATORY	0	0	0	265,148	5.00
6.00	91.00	EMERGENCY	0	0	0	2,866,050	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	5,158,637	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	700,901	700,901				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,431,411		1,431,411			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,556,733	2,164	6,045	3,564,942		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,361,037	103,262	288,516	112,223	12,865,038	5.00
7.00	00700	OPERATION OF PLANT	2,092,132	78,734	219,983	144,402	2,535,251	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	125,720	2,922	8,163	0	136,805	8.00
9.00	00900	HOUSEKEEPING	581,957	7,634	21,330	92,408	703,329	9.00
10.00	01000	DIETARY	488,404	16,200	45,262	77,845	627,711	10.00
11.00	01100	CAFETERIA	18,560	8,485	23,708	15,791	66,544	11.00
13.00	01300	NURSING ADMINISTRATION	1,807,459	21,717	60,677	358,673	2,248,526	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,227,406	17,974	50,219	12,585	1,308,184	14.00
15.00	01500	PHARMACY	1,021,293	5,229	14,610	114,225	1,155,357	15.00
17.00	01700	SOCIAL SERVICE	46,045	449	1,254	11,011	58,759	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,426,513	36,748	102,675	479,539	3,045,475	30.00
31.00	03100	INTENSIVE CARE UNIT	1,116,978	9,633	26,914	232,603	1,386,128	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,035,464	45,415	126,891	267,001	1,474,771	50.00
51.00	05100	RECOVERY ROOM	348,928	0	0	76,970	425,898	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,332,702	20,387	56,963	239,493	1,649,545	54.00
56.00	05600	RADIOISOTOPE	170,046	0	0	19,304	189,350	56.00
57.00	05700	CT SCAN	424,201	4,158	11,617	73,575	513,551	57.00
58.00	05800	MRI	284,304	4,416	12,339	34,674	335,733	58.00
60.00	06000	LABORATORY	3,357,754	19,240	53,757	68,615	3,499,366	60.00
65.00	06500	RESPIRATORY THERAPY	660,837	8,955	25,021	158,888	853,701	65.00
66.00	06600	PHYSICAL THERAPY	743,181	10,098	28,215	149,882	931,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	363,129	4,094	11,440	79,457	458,120	67.00
68.00	06800	SPEECH PATHOLOGY	72,107	1,414	3,951	16,451	93,923	68.00
69.00	06900	ELECTROCARDIOLOGY	733,807	14,692	41,051	64,722	854,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	190,769	0	0	0	190,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	139,035	0	0	0	139,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,916,134	0	0	0	11,916,134	73.00
76.97	07697	CARDIAC REHABILITATION	72,025	7,647	21,365	15,132	116,169	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	992,639	25,193	70,390	200,036	1,288,258	90.00
90.01	09001	CLINIC - DIABETES	131,289	2,198	6,140	9,134	148,761	90.01
91.00	09100	EMERGENCY	2,428,855	20,281	56,667	399,271	2,905,074	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,399,755	499,339	1,395,163	3,523,910	54,120,913	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,179	3,950	11,038	3,611	34,778	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37	165,085	0	0	165,122	192.00
194.00	07950	OCCUPATIONAL HEALTH	16,903	9,023	25,210	0	51,136	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	171,995	23,504	0	37,421	232,920	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	54,604,869	700,901	1,431,411	3,564,942	54,604,869	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 9:00 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,865,038					5.00
7.00	00700	OPERATION OF PLANT	781,415	3,316,666				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,166	18,752	197,723			8.00
9.00	00900	HOUSEKEEPING	216,780	48,999	0	969,108		9.00
10.00	01000	DIETARY	193,473	103,977	0	49,431	974,592	10.00
11.00	01100	CAFETERIA	20,510	54,462	0	25,891	0	11.00
13.00	01300	NURSING ADMINISTRATION	693,041	139,388	0	66,266	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	403,208	115,364	0	54,845	0	14.00
15.00	01500	PHARMACY	356,104	33,563	0	15,956	0	15.00
17.00	01700	SOCIAL SERVICE	18,111	2,881	0	1,370	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	938,676	235,864	65,138	112,132	714,049	30.00
31.00	03100	INTENSIVE CARE UNIT	427,232	61,826	31,264	29,393	260,543	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	454,554	291,494	40,602	138,581	0	50.00
51.00	05100	RECOVERY ROOM	131,270	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	508,423	130,855	0	62,209	0	54.00
56.00	05600	RADIOISOTOPE	58,361	0	0	0	0	56.00
57.00	05700	CT SCAN	158,287	26,687	0	12,687	0	57.00
58.00	05800	MRI	103,480	28,345	0	13,475	0	58.00
60.00	06000	LABORATORY	1,078,575	123,490	0	58,708	0	60.00
65.00	06500	RESPIRATORY THERAPY	263,128	57,478	0	27,326	0	65.00
66.00	06600	PHYSICAL THERAPY	287,069	64,816	0	30,814	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	141,202	26,280	0	12,494	0	67.00
68.00	06800	SPEECH PATHOLOGY	28,949	9,077	0	4,315	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,304	94,302	0	44,832	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,799	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,853	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,672,777	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	35,806	49,081	0	23,333	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	397,067	161,700	0	76,873	0	90.00
90.01	09001	CLINIC - DIABETES	45,851	14,105	0	6,705	0	90.01
91.00	09100	EMERGENCY	895,402	130,175	60,719	61,886	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,715,873	2,022,961	197,723	929,522	974,592	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,719	25,356	0	12,054	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	50,894	1,059,580	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	15,761	57,913	0	27,532	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	71,791	150,856	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	12,865,038	3,316,666	197,723	969,108	974,592	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	167,407					11.00
13.00	01300	NURSING ADMINISTRATION	14,844	3,162,065				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,649	0	1,883,250			14.00
15.00	01500	PHARMACY	4,948	0	61,598	1,627,526		15.00
17.00	01700	SOCIAL SERVICE	825	0	0	0	81,946	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,861	1,216,179	169,032	507	60,039	30.00
31.00	03100	INTENSIVE CARE UNIT	9,896	445,932	85,817	259	21,907	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,896	162,157	559,798	139	0	50.00
51.00	05100	RECOVERY ROOM	3,299	162,157	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,721	0	56,942	574	0	54.00
56.00	05600	RADIOISOTOPE	825	0	5,981	0	0	56.00
57.00	05700	CT SCAN	4,123	0	69,269	91	0	57.00
58.00	05800	MRI	1,649	0	2,978	0	0	58.00
60.00	06000	LABORATORY	16,493	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,247	0	142,684	59	0	65.00
66.00	06600	PHYSICAL THERAPY	7,422	0	11,877	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,299	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	825	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,299	81,079	55,526	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	253,010	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	184,508	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,625,037	0	73.00
76.97	07697	CARDIAC REHABILITATION	825	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,721	364,854	0	454	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	19,792	729,707	223,854	406	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,459	3,162,065	1,882,874	1,627,526	81,946	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	825	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	4,123	0	376	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	167,407	3,162,065	1,883,250	1,627,526	81,946	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 9:00 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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,585,952	0	6,585,952		30.00
31.00	03100	INTENSIVE CARE UNIT	2,760,197	0	2,760,197		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,131,992	0	3,131,992		50.00
51.00	05100	RECOVERY ROOM	722,624	0	722,624		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,419,269	0	2,419,269		54.00
56.00	05600	RADIOISOTOPE	254,517	0	254,517		56.00
57.00	05700	CT SCAN	784,695	0	784,695		57.00
58.00	05800	MRI	485,660	0	485,660		58.00
60.00	06000	LABORATORY	4,776,632	0	4,776,632		60.00
65.00	06500	RESPIRATORY THERAPY	1,352,623	0	1,352,623		65.00
66.00	06600	PHYSICAL THERAPY	1,333,374	0	1,333,374		66.00
67.00	06700	OCCUPATIONAL THERAPY	641,395	0	641,395		67.00
68.00	06800	SPEECH PATHOLOGY	137,089	0	137,089		68.00
69.00	06900	ELECTROCARDIOLOGY	1,396,614	0	1,396,614		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	502,578	0	502,578		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	366,396	0	366,396		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,213,948	0	17,213,948		73.00
76.97	07697	CARDIAC REHABILITATION	225,214	0	225,214		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,299,927	0	2,299,927		90.00
90.01	09001	CLINIC - DIABETES	215,422	0	215,422		90.01
91.00	09100	EMERGENCY	5,027,015	0	5,027,015		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,633,133	0	52,633,133		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	83,732	0	83,732		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,275,596	0	1,275,596		192.00
194.00	07950	OCCUPATIONAL HEALTH	152,342	0	152,342		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	460,066	0	460,066		194.02
194.03	07953	HOME CARE	0	0	0		194.03
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)	54,604,869	0	54,604,869		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,164	6,045	8,209	8,209	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	103,262	288,516	391,778	259	5.00
7.00	00700	OPERATION OF PLANT	0	78,734	219,983	298,717	333	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,922	8,163	11,085	0	8.00
9.00	00900	HOUSEKEEPING	0	7,634	21,330	28,964	213	9.00
10.00	01000	DIETARY	0	16,200	45,262	61,462	179	10.00
11.00	01100	CAFETERIA	0	8,485	23,708	32,193	36	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,717	60,677	82,394	826	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,974	50,219	68,193	29	14.00
15.00	01500	PHARMACY	0	5,229	14,610	19,839	263	15.00
17.00	01700	SOCIAL SERVICE	0	449	1,254	1,703	25	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	36,748	102,675	139,423	1,102	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,633	26,914	36,547	536	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	45,415	126,891	172,306	615	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	177	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,387	56,963	77,350	552	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	44	56.00
57.00	05700	CT SCAN	0	4,158	11,617	15,775	170	57.00
58.00	05800	MRI	0	4,416	12,339	16,755	80	58.00
60.00	06000	LABORATORY	0	19,240	53,757	72,997	158	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,955	25,021	33,976	366	65.00
66.00	06600	PHYSICAL THERAPY	0	10,098	28,215	38,313	345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,094	11,440	15,534	183	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,414	3,951	5,365	38	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,692	41,051	55,743	149	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	7,647	21,365	29,012	35	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	25,193	70,390	95,583	461	90.00
90.01	09001	CLINIC - DIABETES	0	2,198	6,140	8,338	21	90.01
91.00	09100	EMERGENCY	0	20,281	56,667	76,948	920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	499,339	1,395,163	1,894,502	8,115	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,950	11,038	14,988	8	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	165,085	0	165,085	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	9,023	25,210	34,233	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	23,504	0	23,504	86	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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	700,901	1,431,411	2,132,312	8,209	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 9:00 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	392,037					5.00
7.00	00700	OPERATION OF PLANT	23,811	322,861				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,285	1,825	14,195			8.00
9.00	00900	HOUSEKEEPING	6,606	4,770	0	40,553		9.00
10.00	01000	DIETARY	5,895	10,122	0	2,068	79,726	10.00
11.00	01100	CAFETERIA	625	5,302	0	1,083	0	11.00
13.00	01300	NURSING ADMINISTRATION	21,118	13,569	0	2,773	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,286	11,230	0	2,295	0	14.00
15.00	01500	PHARMACY	10,851	3,267	0	668	0	15.00
17.00	01700	SOCIAL SERVICE	552	280	0	57	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,603	22,960	4,676	4,692	58,412	30.00
31.00	03100	INTENSIVE CARE UNIT	13,019	6,018	2,245	1,230	21,314	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,851	28,376	2,915	5,800	0	50.00
51.00	05100	RECOVERY ROOM	4,000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,493	12,738	0	2,603	0	54.00
56.00	05600	RADIOISOTOPE	1,778	0	0	0	0	56.00
57.00	05700	CT SCAN	4,823	2,598	0	531	0	57.00
58.00	05800	MRI	3,153	2,759	0	564	0	58.00
60.00	06000	LABORATORY	32,866	12,021	0	2,457	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,018	5,595	0	1,143	0	65.00
66.00	06600	PHYSICAL THERAPY	8,747	6,309	0	1,289	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,303	2,558	0	523	0	67.00
68.00	06800	SPEECH PATHOLOGY	882	884	0	181	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,023	9,180	0	1,876	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,792	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,306	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,934	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,091	4,778	0	976	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,099	15,741	0	3,217	0	90.00
90.01	09001	CLINIC - DIABETES	1,397	1,373	0	281	0	90.01
91.00	09100	EMERGENCY	27,284	12,672	4,359	2,590	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	387,491	196,925	14,195	38,897	79,726	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	327	2,468	0	504	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,551	103,145	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	480	5,638	0	1,152	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	2,188	14,685	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	392,037	322,861	14,195	40,553	79,726	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	39,239					11.00
13.00	01300	NURSING ADMINISTRATION	3,479	124,159				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	387	0	94,420			14.00
15.00	01500	PHARMACY	1,160	0	3,088	39,136		15.00
17.00	01700	SOCIAL SERVICE	193	0	0	0	2,810	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,766	47,753	8,475	12	2,059	30.00
31.00	03100	INTENSIVE CARE UNIT	2,320	17,510	4,303	6	751	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,320	6,367	28,066	3	0	50.00
51.00	05100	RECOVERY ROOM	773	6,367	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,513	0	2,855	14	0	54.00
56.00	05600	RADIOISOTOPE	193	0	300	0	0	56.00
57.00	05700	CT SCAN	966	0	3,473	2	0	57.00
58.00	05800	MRI	387	0	149	0	0	58.00
60.00	06000	LABORATORY	3,866	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,933	0	7,154	1	0	65.00
66.00	06600	PHYSICAL THERAPY	1,740	0	595	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	773	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	193	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	773	3,184	2,784	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	12,685	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,251	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	39,077	0	73.00
76.97	07697	CARDIAC REHABILITATION	193	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,513	14,326	0	11	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,639	28,652	11,223	10	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,080	124,159	94,401	39,136	2,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	193	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	966	0	19	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	39,239	124,159	94,420	39,136	2,810	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 9:00 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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	324,933	0	324,933		30.00
31.00	03100	INTENSIVE CARE UNIT	105,799	0	105,799		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	260,619	0	260,619		50.00
51.00	05100	RECOVERY ROOM	11,317	0	11,317		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,118	0	114,118		54.00
56.00	05600	RADIOISOTOPE	2,315	0	2,315		56.00
57.00	05700	CT SCAN	28,338	0	28,338		57.00
58.00	05800	MRI	23,847	0	23,847		58.00
60.00	06000	LABORATORY	124,365	0	124,365		60.00
65.00	06500	RESPIRATORY THERAPY	58,186	0	58,186		65.00
66.00	06600	PHYSICAL THERAPY	57,338	0	57,338		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,874	0	23,874		67.00
68.00	06800	SPEECH PATHOLOGY	7,543	0	7,543		68.00
69.00	06900	ELECTROCARDIOLOGY	81,712	0	81,712		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,477	0	14,477		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,557	0	10,557		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151,011	0	151,011		73.00
76.97	07697	CARDIAC REHABILITATION	36,085	0	36,085		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	143,951	0	143,951		90.00
90.01	09001	CLINIC - DIABETES	11,410	0	11,410		90.01
91.00	09100	EMERGENCY	169,297	0	169,297		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,761,092	0	1,761,092		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,488	0	18,488		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	269,781	0	269,781		192.00
194.00	07950	OCCUPATIONAL HEALTH	41,503	0	41,503		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	41,448	0	41,448		194.02
194.03	07953	HOME CARE	0	0	0		194.03
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)	2,132,312	0	2,132,312		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	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	CAP REL COSTS-BLDG & FIXT	165,536					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		120,996				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	511	511	14,907,913			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,388	24,388	469,294	-12,865,038	41,739,831	5.00
7.00	00700	OPERATION OF PLANT	18,595	18,595	603,861	0	2,535,251	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	690	0	0	136,805	8.00
9.00	00900	HOUSEKEEPING	1,803	1,803	386,432	0	703,329	9.00
10.00	01000	DIETARY	3,826	3,826	325,533	0	627,711	10.00
11.00	01100	CAFETERIA	2,004	2,004	66,033	0	66,544	11.00
13.00	01300	NURSING ADMINISTRATION	5,129	5,129	1,499,903	0	2,248,526	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,245	4,245	52,629	0	1,308,184	14.00
15.00	01500	PHARMACY	1,235	1,235	477,667	0	1,155,357	15.00
17.00	01700	SOCIAL SERVICE	106	106	46,045	0	58,759	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,679	8,679	2,005,359	0	3,045,475	30.00
31.00	03100	INTENSIVE CARE UNIT	2,275	2,275	972,700	0	1,386,128	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,726	10,726	1,116,548	0	1,474,771	50.00
51.00	05100	RECOVERY ROOM	0	0	321,874	0	425,898	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,815	4,815	1,001,514	0	1,649,545	54.00
56.00	05600	RADIOISOTOPE	0	0	80,724	0	189,350	56.00
57.00	05700	CT SCAN	982	982	307,676	0	513,551	57.00
58.00	05800	MRI	1,043	1,043	144,998	0	335,733	58.00
60.00	06000	LABORATORY	4,544	4,544	286,934	0	3,499,366	60.00
65.00	06500	RESPIRATORY THERAPY	2,115	2,115	664,439	0	853,701	65.00
66.00	06600	PHYSICAL THERAPY	2,385	2,385	626,777	0	931,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	967	967	332,272	0	458,120	67.00
68.00	06800	SPEECH PATHOLOGY	334	334	68,797	0	93,923	68.00
69.00	06900	ELECTROCARDIOLOGY	3,470	3,470	270,655	0	854,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	190,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	139,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,916,134	73.00
76.97	07697	CARDIAC REHABILITATION	1,806	1,806	63,281	0	116,169	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,950	5,950	836,511	0	1,288,258	90.00
90.01	09001	CLINIC - DIABETES	519	519	38,197	0	148,761	90.01
91.00	09100	EMERGENCY	4,790	4,790	1,669,673	0	2,905,074	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,932	117,932	14,736,326	-12,865,038	41,255,875	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	933	933	15,099	0	34,778	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,989	0	0	0	165,122	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,131	2,131	0	0	51,136	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,551	0	156,488	0	232,920	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	700,901	1,431,411	3,564,942		12,865,038	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.234130	11.830234	0.239131		0.308220	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,209		392,037	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000551		0.009392	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: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	122,042					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	232,929				8.00
9.00	00900	HOUSEKEEPING	1,803	0	75,009			9.00
10.00	01000	DIETARY	3,826	0	3,826	54,022		10.00
11.00	01100	CAFETERIA	2,004	0	2,004	0	203	11.00
13.00	01300	NURSING ADMINISTRATION	5,129	0	5,129	0	18	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,245	0	4,245	0	2	14.00
15.00	01500	PHARMACY	1,235	0	1,235	0	6	15.00
17.00	01700	SOCIAL SERVICE	106	0	106	0	1	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,679	76,736	8,679	39,580	35	30.00
31.00	03100	INTENSIVE CARE UNIT	2,275	36,831	2,275	14,442	12	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,726	47,832	10,726	0	12	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	4	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,815	0	4,815	0	13	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1	56.00
57.00	05700	CT SCAN	982	0	982	0	5	57.00
58.00	05800	MRI	1,043	0	1,043	0	2	58.00
60.00	06000	LABORATORY	4,544	0	4,544	0	20	60.00
65.00	06500	RESPIRATORY THERAPY	2,115	0	2,115	0	10	65.00
66.00	06600	PHYSICAL THERAPY	2,385	0	2,385	0	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	967	0	967	0	4	67.00
68.00	06800	SPEECH PATHOLOGY	334	0	334	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	3,470	0	3,470	0	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,806	0	1,806	0	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,950	0	5,950	0	13	90.00
90.01	09001	CLINIC - DIABETES	519	0	519	0	0	90.01
91.00	09100	EMERGENCY	4,790	71,530	4,790	0	24	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,438	232,929	71,945	54,022	197	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	933	0	933	0	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,989	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,131	0	2,131	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,551	0	0	0	5	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,316,666	197,723	969,108	974,592	167,407	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.176431	0.848855	12.919890	18.040650	824.665025	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	322,861	14,195	40,553	79,726	39,239	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.645491	0.060941	0.540642	1.475806	193.295567	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: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:00 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	15.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	78					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,419,112				14.00
15.00	01500	PHARMACY	0	46,417	11,934,379			15.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,167		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30	127,373	3,716	3,053		30.00
31.00	03100	INTENSIVE CARE UNIT	11	64,667	1,900	1,114		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4	421,833	1,016	0		50.00
51.00	05100	RECOVERY ROOM	4	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,908	4,206	0		54.00
56.00	05600	RADIOISOTOPE	0	4,507	0	0		56.00
57.00	05700	CT SCAN	0	52,197	669	0		57.00
58.00	05800	MRI	0	2,244	0	0		58.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	107,519	433	0		65.00
66.00	06600	PHYSICAL THERAPY	0	8,950	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2	41,841	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	190,654	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	139,035	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,916,134	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9	0	3,328	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0		90.01
91.00	09100	EMERGENCY	18	168,684	2,977	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78	1,418,829	11,934,379	4,167		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	OCCUPATIONAL HEALTH	0	0	0	0		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	283	0	0		194.02
194.03	07953	HOME CARE	0	0	0	0		194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,162,065	1,883,250	1,627,526	81,946		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40,539.294872	1.327062	0.136373	19.665467		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	124,159	94,420	39,136	2,810		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,591.782051	0.066535	0.003279	0.674346		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: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,585,952		6,585,952	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,760,197		2,760,197	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,131,992		3,131,992	0	0	50.00
51.00	05100	RECOVERY ROOM	722,624		722,624	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,419,269		2,419,269	0	0	54.00
56.00	05600	RADIOISOTOPE	254,517		254,517	0	0	56.00
57.00	05700	CT SCAN	784,695		784,695	0	0	57.00
58.00	05800	MRI	485,660		485,660	0	0	58.00
60.00	06000	LABORATORY	4,776,632		4,776,632	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,352,623	0	1,352,623	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,333,374	0	1,333,374	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	641,395	0	641,395	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	137,089	0	137,089	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,396,614		1,396,614	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	502,578		502,578	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	366,396		366,396	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,213,948		17,213,948	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	225,214		225,214	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,299,927		2,299,927	0	0	90.00
90.01	09001	CLINIC - DIABETES	215,422		215,422	0	0	90.01
91.00	09100	EMERGENCY	5,027,015		5,027,015	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,992,840		1,992,840		0	92.00
200.00		Subtotal (see instructions)	54,625,973	0	54,625,973	0	0	200.00
201.00		Less Observation Beds	1,992,840		1,992,840		0	201.00
202.00		Total (see instructions)	52,633,133	0	52,633,133	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,838,786		5,838,786			30.00
31.00	03100	INTENSIVE CARE UNIT	7,114,413		7,114,413			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,593,658	23,218,474	25,812,132	0.121338	0.000000	50.00
51.00	05100	RECOVERY ROOM	149,494	4,628,207	4,777,701	0.151249	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	833,192	13,311,398	14,144,590	0.171038	0.000000	54.00
56.00	05600	RADIOISOTOPE	146,086	2,469,233	2,615,319	0.097318	0.000000	56.00
57.00	05700	CT SCAN	694,619	7,367,107	8,061,726	0.097336	0.000000	57.00
58.00	05800	MRI	234,947	2,722,016	2,956,963	0.164243	0.000000	58.00
60.00	06000	LABORATORY	3,273,728	16,439,536	19,713,264	0.242305	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,536,056	3,029,389	4,565,445	0.296274	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	324,731	2,597,991	2,922,722	0.456210	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	242,286	942,398	1,184,684	0.541406	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	72,645	336,966	409,611	0.334681	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,103,268	9,415,325	10,518,593	0.132776	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	756,612	2,094,612	2,851,224	0.176267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,455	1,384,616	1,429,071	0.256388	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,882,955	57,203,454	62,086,409	0.277258	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,386,287	1,386,287	0.162458	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,090	12,351,897	12,357,987	0.186109	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	82,413	82,413	2.613932	0.000000	90.01
91.00	09100	EMERGENCY	1,336,224	33,888,996	35,225,220	0.142711	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,002	9,291,040	9,312,042	0.214007	0.000000	92.00
200.00		Subtotal (see instructions)	31,205,247	204,161,355	235,366,602			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,205,247	204,161,355	235,366,602			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:00 am

Title XIX | Hospital | Cost

		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	6,585,952		6,585,952	0	6,585,952	30.00
31.00	03100	INTENSIVE CARE UNIT	2,760,197		2,760,197	0	2,760,197	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,131,992		3,131,992	0	3,131,992	50.00
51.00	05100	RECOVERY ROOM	722,624		722,624	0	722,624	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,419,269		2,419,269	0	2,419,269	54.00
56.00	05600	RADIOISOTOPE	254,517		254,517	0	254,517	56.00
57.00	05700	CT SCAN	784,695		784,695	0	784,695	57.00
58.00	05800	MRI	485,660		485,660	0	485,660	58.00
60.00	06000	LABORATORY	4,776,632		4,776,632	0	4,776,632	60.00
65.00	06500	RESPIRATORY THERAPY	1,352,623	0	1,352,623	0	1,352,623	65.00
66.00	06600	PHYSICAL THERAPY	1,333,374	0	1,333,374	0	1,333,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	641,395	0	641,395	0	641,395	67.00
68.00	06800	SPEECH PATHOLOGY	137,089	0	137,089	0	137,089	68.00
69.00	06900	ELECTROCARDIOLOGY	1,396,614		1,396,614	0	1,396,614	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	502,578		502,578	0	502,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	366,396		366,396	0	366,396	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,213,948		17,213,948	0	17,213,948	73.00
76.97	07697	CARDIAC REHABILITATION	225,214		225,214	0	225,214	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,299,927		2,299,927	0	2,299,927	90.00
90.01	09001	CLINIC - DIABETES	215,422		215,422	0	215,422	90.01
91.00	09100	EMERGENCY	5,027,015		5,027,015	0	5,027,015	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,992,840		1,992,840		1,992,840	92.00
200.00		Subtotal (see instructions)	54,625,973	0	54,625,973	0	54,625,973	200.00
201.00		Less Observation Beds	1,992,840		1,992,840		1,992,840	201.00
202.00		Total (see instructions)	52,633,133	0	52,633,133	0	52,633,133	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 9:00 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,838,786		5,838,786			30.00
31.00	03100	INTENSIVE CARE UNIT	7,114,413		7,114,413			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,593,658	23,218,474	25,812,132	0.121338	0.000000	50.00
51.00	05100	RECOVERY ROOM	149,494	4,628,207	4,777,701	0.151249	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	833,192	13,311,398	14,144,590	0.171038	0.000000	54.00
56.00	05600	RADIOISOTOPE	146,086	2,469,233	2,615,319	0.097318	0.000000	56.00
57.00	05700	CT SCAN	694,619	7,367,107	8,061,726	0.097336	0.000000	57.00
58.00	05800	MRI	234,947	2,722,016	2,956,963	0.164243	0.000000	58.00
60.00	06000	LABORATORY	3,273,728	16,439,536	19,713,264	0.242305	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,536,056	3,029,389	4,565,445	0.296274	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	324,731	2,597,991	2,922,722	0.456210	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	242,286	942,398	1,184,684	0.541406	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	72,645	336,966	409,611	0.334681	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,103,268	9,415,325	10,518,593	0.132776	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	756,612	2,094,612	2,851,224	0.176267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,455	1,384,616	1,429,071	0.256388	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,882,955	57,203,454	62,086,409	0.277258	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,386,287	1,386,287	0.162458	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,090	12,351,897	12,357,987	0.186109	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	82,413	82,413	2.613932	0.000000	90.01
91.00	09100	EMERGENCY	1,336,224	33,888,996	35,225,220	0.142711	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,002	9,291,040	9,312,042	0.214007	0.000000	92.00
200.00		Subtotal (see instructions)	31,205,247	204,161,355	235,366,602			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,205,247	204,161,355	235,366,602			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 9:00 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	260,619	25,812,132	0.010097	811,290	8,192	50.00
51.00	05100	RECOVERY ROOM	11,317	4,777,701	0.002369	34,230	81	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,118	14,144,590	0.008068	413,696	3,338	54.00
56.00	05600	RADIOISOTOPE	2,315	2,615,319	0.000885	49,027	43	56.00
57.00	05700	CT SCAN	28,338	8,061,726	0.003515	232,034	816	57.00
58.00	05800	MRI	23,847	2,956,963	0.008065	101,532	819	58.00
60.00	06000	LABORATORY	124,365	19,713,264	0.006309	1,649,977	10,410	60.00
65.00	06500	RESPIRATORY THERAPY	58,186	4,565,445	0.012745	756,147	9,637	65.00
66.00	06600	PHYSICAL THERAPY	57,338	2,922,722	0.019618	175,724	3,447	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,874	1,184,684	0.020152	133,407	2,688	67.00
68.00	06800	SPEECH PATHOLOGY	7,543	409,611	0.018415	44,618	822	68.00
69.00	06900	ELECTROCARDIOLOGY	81,712	10,518,593	0.007768	574,538	4,463	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,477	2,851,224	0.005077	257,263	1,306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,557	1,429,071	0.007387	6,600	49	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151,011	62,086,409	0.002432	2,391,144	5,815	73.00
76.97	07697	CARDIAC REHABILITATION	36,085	1,386,287	0.026030	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	143,951	12,357,987	0.011648	0	0	90.00
90.01	09001	CLINIC - DIABETES	11,410	82,413	0.138449	0	0	90.01
91.00	09100	EMERGENCY	169,297	35,225,220	0.004806	33,542	161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	98,321	9,312,042	0.010558	2,100	22	92.00
200.00		Total (lines 50 through 199)	1,428,681	222,413,403		7,666,869	52,109	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328

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

Worksheet D Part IV

Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
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: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,812,132	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,777,701	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,144,590	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,615,319	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	8,061,726	0.000000	57.00
58.00	05800	MRI	0	0	0	2,956,963	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	19,713,264	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,565,445	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,922,722	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,184,684	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	409,611	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,518,593	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,851,224	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,429,071	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,086,409	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,386,287	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	12,357,987	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	82,413	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	35,225,220	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,312,042	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	222,413,403		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328

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

Worksheet D Part IV

Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	811,290	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	34,230	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	413,696	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	49,027	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	232,034	0	0	0	57.00
58.00	05800	MRI	0.000000	101,532	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,649,977	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	756,147	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	175,724	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	133,407	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	44,618	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	574,538	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	257,263	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,600	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,391,144	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	33,542	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,100	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,666,869	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.121338	0	5,958,652	0	0	50.00
51.00	05100	RECOVERY ROOM	0.151249	0	1,229,225	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171038	0	3,642,520	0	0	54.00
56.00	05600	RADIOISOTOPE	0.097318	0	1,051,998	0	0	56.00
57.00	05700	CT SCAN	0.097336	0	2,813,706	0	0	57.00
58.00	05800	MRI	0.164243	0	883,684	0	0	58.00
60.00	06000	LABORATORY	0.242305	0	5,787,511	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.296274	0	1,256,893	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.456210	0	817,090	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541406	0	262,908	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.334681	0	48,992	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132776	0	3,010,795	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176267	0	447,599	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256388	0	309,658	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277258	0	26,647,352	6,159	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.162458	0	690,129	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.186109	0	5,580,805	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.613932	0	10,231	0	0	90.01
91.00	09100	EMERGENCY	0.142711	0	10,564,653	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.214007	0	4,376,575	0	0	92.00
200.00		Subtotal (see instructions)		0	75,390,976	6,159	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	75,390,976	6,159	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328

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

Worksheet D Part V

Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	723,011	0	50.00
51.00	05100	RECOVERY ROOM	185,919	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,009	0	54.00
56.00	05600	RADIOISOTOPE	102,378	0	56.00
57.00	05700	CT SCAN	273,875	0	57.00
58.00	05800	MRI	145,139	0	58.00
60.00	06000	LABORATORY	1,402,343	0	60.00
65.00	06500	RESPIRATORY THERAPY	372,385	0	65.00
66.00	06600	PHYSICAL THERAPY	372,765	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,340	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,397	0	68.00
69.00	06900	ELECTROCARDIOLOGY	399,761	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,897	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,393	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,388,192	1,708	73.00
76.97	07697	CARDIAC REHABILITATION	112,117	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,038,638	0	90.00
90.01	09001	CLINIC - DIABETES	26,743	0	90.01
91.00	09100	EMERGENCY	1,507,692	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	936,618	0	92.00
200.00		Subtotal (see instructions)	15,927,612	1,708	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	15,927,612	1,708	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.121338	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.151249	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171038	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.097318	0	0	0	0	56.00
57.00	05700	CT SCAN	0.097336	0	0	0	0	57.00
58.00	05800	MRI	0.164243	0	0	0	0	58.00
60.00	06000	LABORATORY	0.242305	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.296274	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.456210	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541406	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.334681	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132776	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176267	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256388	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277258	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.162458	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.186109	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.613932	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.142711	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.214007	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,389	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,378	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)	3,053	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	11	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,593	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,585,952	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)	1,308	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)	1,308	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,584,644	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,584,644	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)	1,504.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,395,920	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,395,920	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,760,197	1,114	2,477.74	557	1,380,101	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,801,083	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,577,104	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)	1,325	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,504.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,992,840	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/29/2020 9:00 am
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	324,933	6,585,952	0.049337	1,992,840	98,321	90.00
91.00	Nursing School cost	0	6,585,952	0.000000	1,992,840	0	91.00
92.00	Allied health cost	0	6,585,952	0.000000	1,992,840	0	92.00
93.00	All other Medical Education	0	6,585,952	0.000000	1,992,840	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:00 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)	4,389	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,378	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)	3,053	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	11	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	66	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,585,952	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)	1,308	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)	1,308	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,584,644	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,584,644	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)	1,504.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	99,266	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)	99,266	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:00 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,760,197	1,114	2,477.74	29	71,854	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)	128,586	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	299,706	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	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)	1,325	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,504.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,992,840	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:00 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	324,933	6,585,952	0.049337	1,992,840	98,321	90.00
91.00	Nursing School cost	0	6,585,952	0.000000	1,992,840	0	91.00
92.00	Allied health cost	0	6,585,952	0.000000	1,992,840	0	92.00
93.00	All other Medical Education	0	6,585,952	0.000000	1,992,840	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,054,713		30.00
31.00	03100	INTENSIVE CARE UNIT		3,294,459		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121338	811,290	98,440	50.00
51.00	05100	RECOVERY ROOM	0.151249	34,230	5,177	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171038	413,696	70,758	54.00
56.00	05600	RADIOISOTOPE	0.097318	49,027	4,771	56.00
57.00	05700	CT SCAN	0.097336	232,034	22,585	57.00
58.00	05800	MRI	0.164243	101,532	16,676	58.00
60.00	06000	LABORATORY	0.242305	1,649,977	399,798	60.00
65.00	06500	RESPIRATORY THERAPY	0.296274	756,147	224,027	65.00
66.00	06600	PHYSICAL THERAPY	0.456210	175,724	80,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541406	133,407	72,227	67.00
68.00	06800	SPEECH PATHOLOGY	0.334681	44,618	14,933	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132776	574,538	76,285	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176267	257,263	45,347	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256388	6,600	1,692	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277258	2,391,144	662,964	73.00
76.97	07697	CARDIAC REHABILITATION	0.162458	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.186109	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.613932	0	0	90.01
91.00	09100	EMERGENCY	0.142711	33,542	4,787	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.214007	2,100	449	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,666,869	1,801,083	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)		7,666,869		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121338	0	0	50.00
51.00	05100	RECOVERY ROOM	0.151249	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171038	0	0	54.00
56.00	05600	RADIOISOTOPE	0.097318	0	0	56.00
57.00	05700	CT SCAN	0.097336	0	0	57.00
58.00	05800	MRI	0.164243	0	0	58.00
60.00	06000	LABORATORY	0.242305	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.296274	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.456210	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541406	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.334681	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132776	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176267	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256388	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277258	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.162458	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.186109	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.613932	0	0	90.01
91.00	09100	EMERGENCY	0.142711	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.214007	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 9:00 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		122,099		30.00
31.00	03100	INTENSIVE CARE UNIT		145,284		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121338	89,293	10,835	50.00
51.00	05100	RECOVERY ROOM	0.151249	5,049	764	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171038	33,415	5,715	54.00
56.00	05600	RADIOISOTOPE	0.097318	7,237	704	56.00
57.00	05700	CT SCAN	0.097336	33,184	3,230	57.00
58.00	05800	MRI	0.164243	10,467	1,719	58.00
60.00	06000	LABORATORY	0.242305	78,697	19,069	60.00
65.00	06500	RESPIRATORY THERAPY	0.296274	51,166	15,159	65.00
66.00	06600	PHYSICAL THERAPY	0.456210	5,077	2,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541406	5,128	2,776	67.00
68.00	06800	SPEECH PATHOLOGY	0.334681	3,272	1,095	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132776	14,040	1,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176267	28,256	4,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256388	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277258	164,057	45,486	73.00
76.97	07697	CARDIAC REHABILITATION	0.162458	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.186109	3,548	660	90.00
90.01	09001	CLINIC - DIABETES	2.613932	0	0	90.01
91.00	09100	EMERGENCY	0.142711	85,578	12,213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.214007	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		617,464	128,586	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)		617,464		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3

Component CCN: 15-Z328 | Date/Time Prepared: 6/29/2020 9:00 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121338	0	0	50.00
51.00	05100	RECOVERY ROOM	0.151249	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171038	0	0	54.00
56.00	05600	RADIOISOTOPE	0.097318	0	0	56.00
57.00	05700	CT SCAN	0.097336	0	0	57.00
58.00	05800	MRI	0.164243	0	0	58.00
60.00	06000	LABORATORY	0.242305	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.296274	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.456210	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541406	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.334681	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132776	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176267	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256388	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277258	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.162458	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.186109	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.613932	0	0	90.01
91.00	09100	EMERGENCY	0.142711	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.214007	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 9:00 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,929,320	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	15,929,320	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	16,088,613	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	95,713	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	13,915,595	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,077,305	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,077,305	30.00
31.00	Primary payer payments	253	31.00
32.00	Subtotal (line 30 minus line 31)	2,077,052	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)	2,456,200	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,596,530	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,901,806	36.00
37.00	Subtotal (see instructions)	3,673,582	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,673,582	40.00
40.01	Sequestration adjustment (see instructions)	73,472	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,140,407	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	459,703	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	882,097	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: 15-1328

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

Worksheet E-1 Part I
Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,811,617		2,804,807	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		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/24/2019	48,400	07/24/2019	335,600	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		48,400		335,600	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,860,017		3,140,407	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		459,703	6.01
6.02	SETTLEMENT TO PROGRAM		29,830		0	6.02
7.00	Total Medicare program liability (see instructions)		4,830,187		3,600,110	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Swing Beds - SNF | Cost

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1328	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/29/2020 9:00 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1328 | Component CCN: 15-Z328

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

Worksheet E-2

Date/Time Prepared: 6/29/2020 9:00 am

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 9:00 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,577,104	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,577,104	4.00
5.00	Primary payer payments	10,329	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,622,546	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,622,546	19.00
20.00	Deductibles (exclude professional component)	721,508	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,901,038	22.00
23.00	Coinsurance	2,046	23.00
24.00	Subtotal (line 22 minus line 23)	4,898,992	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45,800	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	29,770	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,377	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,928,762	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	4,928,762	30.00
30.01	Sequestration adjustment (see instructions)	98,575	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	4,860,017	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-29,830	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	308,839	34.00

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

Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/29/2020 9:00 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	53,306,795	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	6,193,072	0	0	0	4.00
5.00	Other receivable	-2,723,192	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,017,061	0	0	0	7.00
8.00	Prepaid expenses	209,362	0	0	0	8.00
9.00	Other current assets	90,698	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	58,093,796	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	931,334	0	0	0	12.00
13.00	Land improvements	1,119,735	0	0	0	13.00
14.00	Accumulated depreciation	-1,061,915	0	0	0	14.00
15.00	Buildings	19,459,209	0	0	0	15.00
16.00	Accumulated depreciation	-12,880,465	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	242,498	0	0	0	21.00
22.00	Accumulated depreciation	-200,363	0	0	0	22.00
23.00	Major movable equipment	15,150,638	0	0	0	23.00
24.00	Accumulated depreciation	-10,818,531	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	281,213	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,223,353	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,563,345	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,563,345	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	74,880,494	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,184,770	0	0	0	37.00
38.00	Salaries, wages, and fees payable	610,568	0	0	0	38.00
39.00	Payroll taxes payable	875,065	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,593,792	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,264,195	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	89,812	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	58,972	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	148,784	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,412,979	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	67,467,515				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)	67,467,515	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	74,880,494	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/29/2020 9:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		56,499,178		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,881,542				2.00
3.00	Total (sum of line 1 and line 2)		71,380,720		0		3.00
4.00	ROUNDING	2		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)		2		0		10.00
11.00	Subtotal (line 3 plus line 10)		71,380,722		0		11.00
12.00	INTERCOMPANY CAPITAL TRANSFER	3,913,207		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)		3,913,207		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		67,467,515		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	ROUNDING		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	INTERCOMPANY CAPITAL TRANSFER		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: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/29/2020 9:00 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,829,403		5,829,403	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	9,383		9,383	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)	5,838,786		5,838,786	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,114,413		7,114,413	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)	7,114,413		7,114,413	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,953,199		12,953,199	17.00
18.00	Ancillary services	16,888,732	148,547,009	165,435,741	18.00
19.00	Outpatient services	1,363,316	55,614,346	56,977,662	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	1,513,027	1,513,027	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,205,247	205,674,382	236,879,629	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		59,740,636		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)		59,740,636		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 6/29/2020 9:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	236,879,629	1.00
2.00	Less contractual allowances and discounts on patients' accounts	165,028,524	2.00
3.00	Net patient revenues (line 1 minus line 2)	71,851,105	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	59,740,636	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,110,469	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	2,771,073	24.00
25.00	Total other income (sum of lines 6-24)	2,771,073	25.00
26.00	Total (line 5 plus line 25)	14,881,542	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,881,542	29.00