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: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 8:06 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/29/2020 Time: 8:06 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 IU HEALTH BLACKFORD HOSPITAL (15-1302) 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) JONATHAN VANATOR
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	246,637	-174,216	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	134,077	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	380,714	-174,216	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:06 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 410 PILGRIM STREET	PO Box:			1.00
2.00	City: HARTFORD CITY	State: IN	Zip Code: 47348	County: BLACKFORD	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	IU HEALTH BLACKFORD HOSPITAL	151302	99915	1	02/10/2000	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	BLACKFORD COMMUNITY SWING BED	15Z302	99915		02/10/2000	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:06 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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 8:06 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:06 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:06 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: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:06 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:	27,090	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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:06 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: IU HEALTH, INC	Contractor's Name: WPS		Contractor's Number: 08101	141.00
142.00	Street: 340 W. 10TH STREET	PO Box:			142.00
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46204	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	8	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/29/2020 8:06 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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:06 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.					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.			Y		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: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:06 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, GOVERNMENT PROGRAMS		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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 6/29/2020 8:06 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	15	5,475	24,360.00	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)		15	5,475	24,360.00	0	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)		15	5,475	24,360.00	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)		15				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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:06 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)	628	10	1,015			1.00
2.00	HMO and other (see instructions)	168	73				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	855	0	855			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	182			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,483	10	2,052			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)	1,483	10	2,052	0.00	94.87	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	94.87	27.00
28.00	Observation Bed Days		2	337			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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:06 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	176	3	277	1.00
2.00	HMO and other (see instructions)			39	19		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	176	3	277	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: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/29/2020 8:06 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)	0.415938	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	859,606	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	7,788,172	6.00
7.00	Medicaid cost (line 1 times line 6)	3,239,397	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)	2,379,791	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)	2,379,791	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,214,306	59,265	1,273,571	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	505,076	59,265	564,341	21.00
22.00	Payments received from patients for amounts previously written off as charity care	6,948	0	6,948	22.00
23.00	Cost of charity care (line 21 minus line 22)	498,128	59,265	557,393	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)	1,899,821	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	278,546	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	428,532	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,471,289	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	761,951	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,319,344	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,699,135	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		6,206	6,206	879,867	886,073	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	63,635	63,635	887,072	950,707	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	507,822	4,301,351	4,809,173	-82,871	4,726,302	5.00
7.00	00700	OPERATION OF PLANT	192,112	1,412,528	1,604,640	-526,842	1,077,798	7.00
9.00	00900	HOUSEKEEPING	159,977	187,611	347,588	-74,303	273,285	9.00
10.00	01000	DIETARY	226,708	217,410	444,118	-234,631	209,487	10.00
11.00	01100	CAFETERIA	0	0	0	149,141	149,141	11.00
13.00	01300	NURSING ADMINISTRATION	323,806	112,438	436,244	-47,344	388,900	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,046	8,046	239,264	247,310	14.00
15.00	01500	PHARMACY	0	1,487,466	1,487,466	-614,766	872,700	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,632,580	560,338	2,192,918	-412,241	1,780,677	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	167,727	171,942	339,669	-85,248	254,421	50.00
53.00	05300	ANESTHESIOLOGY	0	190,555	190,555	-4,924	185,631	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,233	1,070,274	1,643,507	-398,843	1,244,664	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,215,932	1,215,932	-12,584	1,203,348	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	479,106	67,181	546,287	-36,873	509,414	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	324,605	41,975	366,580	-18,945	347,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,036	0	73,036	15,499	88,535	67.00
68.00	06800	SPEECH PATHOLOGY	8,115	0	8,115	0	8,115	68.00
69.00	06900	ELECTROCARDIOLOGY	9,943	432	10,375	-432	9,943	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	26,951	26,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,318	3,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	632,101	632,101	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	30,563	8,563	39,126	-6,251	32,875	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	43,099	20,841	63,940	-8,028	55,912	90.00
91.00	09100	EMERGENCY	691,192	2,087,442	2,778,634	-268,085	2,510,549	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,443,624	13,232,166	18,675,790	2	18,675,792	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34	34	-2	32	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	5,443,624	13,232,200	18,675,824	0	18,675,824	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	150,282	1,036,355		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	339,101	1,289,808		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-90,141	4,636,161		5.00
7.00	00700	OPERATION OF PLANT	24,631	1,102,429		7.00
9.00	00900	HOUSEKEEPING	-14,785	258,500		9.00
10.00	01000	DIETARY	0	209,487		10.00
11.00	01100	CAFETERIA	-59,300	89,841		11.00
13.00	01300	NURSING ADMINISTRATION	101,110	490,010		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	247,310		14.00
15.00	01500	PHARMACY	-174,311	698,389		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,780,677		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-460	253,961		50.00
53.00	05300	ANESTHESIOLOGY	-185,618	13		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,569	1,333,233		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	1,203,348		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	-1,761	507,653		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	-5,359	342,276		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	88,535		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,115		68.00
69.00	06900	ELECTROCARDIOLOGY	50,640	60,583		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,951		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,318		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	632,101		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	6,572	39,447		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	55,912		90.00
91.00	09100	EMERGENCY	-1,390,216	1,120,333		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,161,046	17,514,746		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,161,046	17,514,778		200.00

RECLASSIFICATIONS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:06 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	94,280	54,861	1.00
	0		94,280	54,861	
	B - MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	239,264	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	26,951	2.00
3.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,318	3.00
4.00	OPERATION OF PLANT	7.00	0	22	4.00
5.00	NURSING ADMINISTRATION	13.00	0	13	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
	0		0	269,568	
	C - DRUGS CHARGED TO PATIENTS				
1.00	PHARMACY	15.00	0	18,694	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	632,101	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
	0		0	650,795	
	E - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	896,152	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
	0		0	896,152	
	F - DEPRECIATION				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	867,009	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
	0		0	867,009	
	G - OUTPATIENT THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	15,337	162	1.00
	0		15,337	162	
	H - AUTO & PROPERTY INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	12,858	1.00
	0		0	12,858	
	I - MALPRACTICE INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,078	1.00
	TOTALS		0	3,078	
500.00	Grand Total: Increases		109,617	2,754,483	500.00

RECLASSIFICATIONS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:06 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	94,280	54,861	0		1.00
	0		94,280	54,861			
	B - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	100	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	147	0		2.00
3.00	HOUSEKEEPING	9.00	0	5,980	0		3.00
4.00	DIETARY	10.00	0	738	0		4.00
5.00	PHARMACY	15.00	0	4,411	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	58,697	0		6.00
7.00	OPERATING ROOM	50.00	0	50,018	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	4,916	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,336	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	25,247	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	2,090	0		11.00
12.00	CARDIAC REHABILITATION	76.97	0	995	0		12.00
13.00	CLINIC	90.00	0	4,236	0		13.00
14.00	EMERGENCY	91.00	0	86,655	0		14.00
15.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2	0		15.00
	0		0	269,568			
	C - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	605,093	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,980	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	9,225	0		3.00
4.00	OPERATING ROOM	50.00	0	561	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	8	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,390	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	432	0		7.00
8.00	CLINIC	90.00	0	949	0		8.00
9.00	EMERGENCY	91.00	0	6,157	0		9.00
	0		0	650,795			
	E - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	56,375	0		1.00
2.00	OPERATION OF PLANT	7.00	0	46,971	0		2.00
3.00	HOUSEKEEPING	9.00	0	67,059	0		3.00
4.00	DIETARY	10.00	0	76,107	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	47,357	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	322,380	0		6.00
7.00	OPERATING ROOM	50.00	0	25,403	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	108,932	0		8.00
9.00	CARDIAC REHABILITATION	76.97	0	62	0		9.00
10.00	CLINIC	90.00	0	1,771	0		10.00
11.00	EMERGENCY	91.00	0	143,735	0		11.00
	0		0	896,152			
	F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,569	9		1.00
2.00	OPERATION OF PLANT	7.00	0	479,893	0		2.00
3.00	HOUSEKEEPING	9.00	0	1,264	0		3.00
4.00	DIETARY	10.00	0	8,645	0		4.00
5.00	PHARMACY	15.00	0	23,956	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	21,939	0		6.00
7.00	OPERATING ROOM	50.00	0	9,266	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	245,185	0		8.00
9.00	LABORATORY	60.00	0	12,584	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	11,626	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	1,356	0		11.00
12.00	CARDIAC REHABILITATION	76.97	0	5,194	0		12.00
13.00	CLINIC	90.00	0	1,072	0		13.00
14.00	EMERGENCY	91.00	0	28,460	0		14.00
	0		0	867,009			
	G - OUTPATIENT THERAPY						
1.00	PHYSICAL THERAPY	66.00	15,337	162	0		1.00
	0		15,337	162			
	H - AUTO & PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,858	12		1.00
	0		0	12,858			
	I - MALPRACTICE INSURANCE						
1.00	EMERGENCY	91.00	0	3,078	0		1.00
	TOTALS		0	3,078			
500.00	Grand Total: Decreases		109,617	2,754,483			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 6/29/2020 8:06 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	190,324	0	0	0	0	1.00
2.00	Land Improvements	259,436	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,007,745	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,834,229	584,954	0	584,954	888,909	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,291,734	584,954	0	584,954	888,909	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,291,734	584,954	0	584,954	888,909	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	190,324	0				1.00
2.00	Land Improvements	259,436	218,386				2.00
3.00	Buildings and Fixtures	15,007,745	2,290,839				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4,530,274	2,145,326				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	19,987,779	4,654,551				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	19,987,779	4,654,551				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 6/29/2020 8:06 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	6,206	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,206	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	6,206		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	6,206		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 6/29/2020 8:06 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	19,987,779	0	19,987,779	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	19,987,779	0	19,987,779	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,131,307	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,131,307	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-107,810	12,858	0	0	1,036,355	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-107,810	12,858	0	0	1,036,355	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:06 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-107,810	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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	-1,487,530			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,048,302			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-59,300	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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	B	0	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:06 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-4,213	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CHARITY CONTRIBUTIONS	A	-95	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-77,171	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-542	OPERATION OF PLANT	7.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-14,785	HOUSEKEEPING	9.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-77,160	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-4,910	RESPIRATORY THERAPY	65.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-1,138	EMERGENCY	91.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-34	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	MARKETING/ADVERTISING COSTS	A	-3,881	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TELEPHONE EQUIPMENT	A	-48	OPERATING ROOM	50.00	0	33.09
33.10	TELEPHONE EQUIPMENT	A	-250	RESPIRATORY THERAPY	65.00	0	33.10
33.11	EMPLOYEE BENEFITS	A	-896,152	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	HOSPITAL ASSESSMENT FEES	A	-480,568	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	NON-ALLOWABLE PATIENT REIMB	A	-230	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	PTO EXPENSE ALLOCATION	A	6,469	ADMINISTRATIVE & GENERAL	5.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,161,046				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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:06 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	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	262,305	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,235,253	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,965,192	2,638,140	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	891,964	753,681	4.00
4.01	7.00	OPERATION OF PLANT	RELATED PARTY	254,439	229,266	4.01
4.02	13.00	NURSING ADMINISTRATION	RELATED PARTY	189,527	11,257	4.02
4.03	15.00	PHARMACY	RELATED PARTY	174,171	348,482	4.03
4.04	50.00	OPERATING ROOM	RELATED PARTY	13,256	13,668	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	154,718	154,961	4.05
4.06	65.00	RESPIRATORY THERAPY	RELATED PARTY	28,050	24,651	4.06
4.07	66.00	PHYSICAL THERAPY	RELATED PARTY	29,671	35,030	4.07
4.08	69.00	ELECTROCARDIOLOGY	RELATED PARTY	50,640	0	4.08
4.09	76.97	CARDIAC REHABILITATION	RELATED PARTY	8,252	0	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	24,802	24,802	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	305,346	305,346	4.11
4.12	7.00	OPERATION OF PLANT	RELATED PARTY	118,617	118,617	4.12
4.13	10.00	DIETARY	RELATED PARTY	16,926	16,926	4.13
4.14	13.00	NURSING ADMINISTRATION	RELATED PARTY	187	187	4.14
4.15	15.00	PHARMACY	RELATED PARTY	496,195	496,195	4.15
4.16	30.00	ADULTS & PEDIATRICS	RELATED PARTY	6,897	6,897	4.16
4.17	50.00	OPERATING ROOM	RELATED PARTY	5,679	5,679	4.17
4.18	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	298,322	298,322	4.18
4.19	60.00	LABORATORY	RELATED PARTY	1,147,700	1,147,700	4.19
4.20	65.00	RESPIRATORY THERAPY	RELATED PARTY	481,262	481,262	4.20
4.21	66.00	PHYSICAL THERAPY	RELATED PARTY	325,282	325,282	4.21
4.22	67.00	OCCUPATIONAL THERAPY	RELATED PARTY	73,036	73,036	4.22
4.23	68.00	SPEECH PATHOLOGY	RELATED PARTY	8,115	8,115	4.23
4.24	69.00	ELECTROCARDIOLOGY	RELATED PARTY	9,943	9,943	4.24
4.25	76.97	CARDIAC REHABILITATION	RELATED PARTY	29,297	29,297	4.25
4.26	90.00	CLINIC	RELATED PARTY	9,587	9,587	4.26
4.27	91.00	EMERGENCY	RELATED PARTY	1,689,806	1,689,806	4.27
4.28	0.00			0	0	4.28
4.29	0.00			0	0	4.29
4.30	0.00			0	0	4.30
4.31	0.00			0	0	4.31
4.32	0.00			0	0	4.32
4.33	0.00			0	0	4.33
4.34	0.00			0	0	4.34
4.35	0.00			0	0	4.35
4.36	0.00			0	0	4.36
4.37	0.00			0	0	4.37
4.38	0.00			0	0	4.38
4.39	0.00			0	0	4.39
4.40	0.00			0	0	4.40
4.41	0.00			0	0	4.41
4.42	0.00			0	0	4.42
4.43	0.00			0	0	4.43
4.44	0.00			0	0	4.44
4.45	0.00			0	0	4.45
4.46	0.00			0	0	4.46
4.47	0.00			0	0	4.47
4.48	0.00			0	0	4.48
4.49	0.00			0	0	4.49
4.50	0.00			0	0	4.50
5.00	0		0	11,304,437	9,256,135	5.00

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

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:06 am

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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	B		0.00	IU HEALTH	100.00	6.00
7.00	B		0.00	BALL HOSPITAL	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:06 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	262,305	9		1.00
2.00	1,235,253	0		2.00
3.00	327,052	0		3.00
4.00	138,283	0		4.00
4.01	25,173	0		4.01
4.02	178,270	0		4.02
4.03	-174,311	0		4.03
4.04	-412	0		4.04
4.05	-243	0		4.05
4.06	3,399	0		4.06
4.07	-5,359	0		4.07
4.08	50,640	0		4.08
4.09	8,252	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
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
4.29	0	0		4.29
4.30	0	0		4.30
4.31	0	0		4.31
4.32	0	0		4.32
4.33	0	0		4.33
4.34	0	0		4.34
4.35	0	0		4.35
4.36	0	0		4.36
4.37	0	0		4.37
4.38	0	0		4.38
4.39	0	0		4.39
4.40	0	0		4.40
4.41	0	0		4.41
4.42	0	0		4.42
4.43	0	0		4.43
4.44	0	0		4.44
4.45	0	0		4.45
4.46	0	0		4.46
4.47	0	0		4.47
4.48	0	0		4.48
4.49	0	0		4.49
4.50	0	0		4.50
5.00	2,048,302			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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/29/2020 8:06 am

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOSPITAL		6.00
7.00	HOSPITAL		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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/29/2020 8:06 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	53.00	ANESTHESIOLOGY	185,618	185,618	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	61,154	-88,846	150,000	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	1,680	1,680	0	0	0	3.00
4.00	91.00	EMERGENCY	1,739,174	1,389,078	350,096	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,987,626	1,487,530	500,096		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	185,618		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	-88,846		2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	1,680		3.00
4.00	91.00	EMERGENCY	0	0	0	1,389,078		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,487,530		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,036,355	1,036,355				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,289,808	0	0	1,289,808		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,636,161	131,335	0	120,323	4,887,819	5.00
7.00	00700	OPERATION OF PLANT	1,102,429	200,798	0	45,519	1,348,746	7.00
9.00	00900	HOUSEKEEPING	258,500	21,518	0	37,905	317,923	9.00
10.00	01000	DIETARY	209,487	42,123	0	31,377	282,987	10.00
11.00	01100	CAFETERIA	89,841	29,966	0	22,339	142,146	11.00
13.00	01300	NURSING ADMINISTRATION	490,010	4,366	0	76,722	571,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	247,310	22,974	0	0	270,284	14.00
15.00	01500	PHARMACY	698,389	15,611	0	0	714,000	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,780,677	168,236	0	386,822	2,335,735	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	253,961	90,782	0	39,741	384,484	50.00
53.00	05300	ANESTHESIOLOGY	13	0	0	0	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,333,233	82,192	0	135,821	1,551,246	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,203,348	31,564	0	0	1,234,912	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	507,653	11,958	0	113,519	633,130	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	342,276	55,422	0	73,278	470,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	88,535	4,766	0	20,939	114,240	67.00
68.00	06800	SPEECH PATHOLOGY	8,115	114	0	1,923	10,152	68.00
69.00	06900	ELECTROCARDIOLOGY	60,583	0	0	2,356	62,939	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,951	0	0	0	26,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,318	0	0	0	3,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	632,101	0	0	0	632,101	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	39,447	5,194	0	7,242	51,883	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,912	19,406	0	10,212	85,530	90.00
91.00	09100	EMERGENCY	1,120,333	90,553	0	163,770	1,374,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,514,746	1,028,878	0	1,289,808	17,507,269	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32	7,477	0	0	7,509	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,514,778	1,036,355	0	1,289,808	17,514,778	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
			5.00	7.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,887,819					5.00
7.00	00700	OPERATION OF PLANT	522,091	1,870,837				7.00
9.00	00900	HOUSEKEEPING	123,066	57,165	498,154			9.00
10.00	01000	DIETARY	109,543	111,904	30,736	535,170		10.00
11.00	01100	CAFETERIA	55,024	79,607	21,865	0	298,642	11.00
13.00	01300	NURSING ADMINISTRATION	221,069	11,600	3,186	0	11,180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,625	61,032	16,763	0	0	14.00
15.00	01500	PHARMACY	276,385	41,471	11,391	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	904,147	446,936	122,761	535,170	118,854	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	148,831	241,171	66,241	0	10,520	50.00
53.00	05300	ANESTHESIOLOGY	5	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	600,478	218,350	59,973	0	37,377	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	478,027	83,853	23,031	0	36,552	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	245,081	31,767	8,725	0	23,433	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	182,312	147,235	40,440	0	15,429	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,222	12,661	3,478	0	3,053	67.00
68.00	06800	SPEECH PATHOLOGY	3,930	303	83	0	330	68.00
69.00	06900	ELECTROCARDIOLOGY	24,363	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,433	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,284	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	244,683	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	20,084	13,799	3,790	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,108	51,555	14,160	0	3,465	90.00
91.00	09100	EMERGENCY	532,121	240,564	66,075	0	38,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,884,912	1,850,973	492,698	535,170	298,642	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,907	19,864	5,456	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,887,819	1,870,837	498,154	535,170	298,642	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	15.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	818,133					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	452,704				14.00
15.00	01500	PHARMACY	0	7,169	1,050,416			15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	537,244	70,534	14,890	5,086,271	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,496	62,467	671	953,881	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,811	13	7,842	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,181	3,159	2,510,764	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	30,583	0	1,886,958	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	40,246	0	982,382	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	3,129	0	859,521	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	191	0	177,845	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,798	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	87,302	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	42,120	0	79,504	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,186	0	9,788	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,020,242	1,897,026	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,700	0	91,256	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,607	5,929	1,532	215,886	0	90.00
91.00	09100	EMERGENCY	220,786	135,455	9,909	2,618,015	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	818,133	452,701	1,050,416	17,479,039	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3	0	35,739	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	818,133	452,704	1,050,416	17,514,778	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,086,271		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	953,881		50.00
53.00	05300	ANESTHESIOLOGY	7,842		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,510,764		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	1,886,958		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		62.00
65.00	06500	RESPIRATORY THERAPY	982,382		65.00
65.01	06501	SLEEP LAB	0		65.01
66.00	06600	PHYSICAL THERAPY	859,521		66.00
67.00	06700	OCCUPATIONAL THERAPY	177,845		67.00
68.00	06800	SPEECH PATHOLOGY	14,798		68.00
69.00	06900	ELECTROCARDIOLOGY	87,302		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,504		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,788		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,897,026		73.00
76.00	03140	CARDIOLOGY	0		76.00
76.97	07697	CARDIAC REHABILITATION	91,256		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	215,886		90.00
91.00	09100	EMERGENCY	2,618,015		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,479,039		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,739		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	17,514,778		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	131,335	0	131,335	0	5.00
7.00	00700	OPERATION OF PLANT	0	200,798	0	200,798	0	7.00
9.00	00900	HOUSEKEEPING	0	21,518	0	21,518	0	9.00
10.00	01000	DIETARY	0	42,123	0	42,123	0	10.00
11.00	01100	CAFETERIA	0	29,966	0	29,966	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,366	0	4,366	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22,974	0	22,974	0	14.00
15.00	01500	PHARMACY	0	15,611	0	15,611	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	168,236	0	168,236	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	90,782	0	90,782	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	82,192	0	82,192	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	31,564	0	31,564	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	11,958	0	11,958	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	55,422	0	55,422	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,766	0	4,766	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	114	0	114	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	5,194	0	5,194	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	19,406	0	19,406	0	90.00
91.00	09100	EMERGENCY	0	90,553	0	90,553	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,028,878	0	1,028,878	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,477	0	7,477	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,036,355	0	1,036,355	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
			5.00	7.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	131,335					5.00
7.00	00700	OPERATION OF PLANT	14,028	214,826				7.00
9.00	00900	HOUSEKEEPING	3,307	6,564	31,389			9.00
10.00	01000	DIETARY	2,943	12,850	1,937	59,853		10.00
11.00	01100	CAFETERIA	1,478	9,141	1,378	0	41,963	11.00
13.00	01300	NURSING ADMINISTRATION	5,940	1,332	201	0	1,571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,811	7,008	1,056	0	0	14.00
15.00	01500	PHARMACY	7,426	4,762	718	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,296	51,321	7,735	59,853	16,700	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,999	27,693	4,174	0	1,478	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,135	25,073	3,779	0	5,252	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12,844	9,629	1,451	0	5,136	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	6,585	3,648	550	0	3,293	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	4,899	16,907	2,548	0	2,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,188	1,454	219	0	429	67.00
68.00	06800	SPEECH PATHOLOGY	106	35	5	0	46	68.00
69.00	06900	ELECTROCARDIOLOGY	655	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	35	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,574	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	540	1,584	239	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	890	5,920	892	0	487	90.00
91.00	09100	EMERGENCY	14,298	27,624	4,163	0	5,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,257	212,545	31,045	59,853	41,963	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78	2,281	344	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	131,335	214,826	31,389	59,853	41,963	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	15.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,410					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,849				14.00
15.00	01500	PHARMACY	0	536	29,053			15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,806	5,274	412	342,633	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	647	4,671	19	133,463	0	50.00
53.00	05300	ANESTHESIOLOGY	0	584	0	584	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,004	87	135,522	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,287	0	62,911	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,009	0	29,043	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	234	0	82,178	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14	0	8,070	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	306	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	655	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,149	0	3,429	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	388	0	423	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	28,219	34,793	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	127	0	7,684	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	338	443	42	28,418	0	90.00
91.00	09100	EMERGENCY	3,619	10,129	274	156,063	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,410	33,849	29,053	1,026,175	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,180	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,410	33,849	29,053	1,036,355	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	342,633		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	133,463		50.00
53.00	05300	ANESTHESIOLOGY	584		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,522		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	62,911		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		62.00
65.00	06500	RESPIRATORY THERAPY	29,043		65.00
65.01	06501	SLEEP LAB	0		65.01
66.00	06600	PHYSICAL THERAPY	82,178		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,070		67.00
68.00	06800	SPEECH PATHOLOGY	306		68.00
69.00	06900	ELECTROCARDIOLOGY	655		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,429		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	423		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,793		73.00
76.00	03140	CARDIOLOGY	0		76.00
76.97	07697	CARDIAC REHABILITATION	7,684		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	28,418		90.00
91.00	09100	EMERGENCY	156,063		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,026,175		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,180		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,036,355		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	36,314					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,443,624			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,602	0	507,822	-4,887,819	12,626,959	5.00
7.00	00700	OPERATION OF PLANT	7,036	0	192,112	0	1,348,746	7.00
9.00	00900	HOUSEKEEPING	754	0	159,977	0	317,923	9.00
10.00	01000	DIETARY	1,476	0	132,428	0	282,987	10.00
11.00	01100	CAFETERIA	1,050	0	94,280	0	142,146	11.00
13.00	01300	NURSING ADMINISTRATION	153	0	323,806	0	571,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	805	0	0	0	270,284	14.00
15.00	01500	PHARMACY	547	0	0	0	714,000	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,895	0	1,632,580	0	2,335,735	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,181	0	167,727	0	384,484	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,880	0	573,233	0	1,551,246	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,106	0	0	0	1,234,912	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	419	0	479,106	0	633,130	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,942	0	309,268	0	470,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	167	0	88,373	0	114,240	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	8,115	0	10,152	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	9,943	0	62,939	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	26,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	632,101	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	182	0	30,563	0	51,883	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	680	0	43,099	0	85,530	90.00
91.00	09100	EMERGENCY	3,173	0	691,192	0	1,374,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,052	0	5,443,624	-4,887,819	12,619,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	262	0	0	0	7,509	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,036,355	0	1,289,808		4,887,819	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.538718	0.000000	0.236939		0.387094	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		131,335	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.010401	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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	24,676					7.00
9.00	00900	HOUSEKEEPING	754	23,922				9.00
10.00	01000	DIETARY	1,476	1,476	1,015			10.00
11.00	01100	CAFETERIA	1,050	1,050	0	7,239		11.00
13.00	01300	NURSING ADMINISTRATION	153	153	0	271	3,335	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	805	805	0	0	0	14.00
15.00	01500	PHARMACY	547	547	0	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,895	5,895	1,015	2,881	2,190	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,181	3,181	0	255	161	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,880	2,880	0	906	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,106	1,106	0	886	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	419	419	0	568	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,942	1,942	0	374	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	167	167	0	74	0	67.00
68.00	06800	SPEECH PATHOLOGY	4	4	0	8	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	182	182	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	680	680	0	84	84	90.00
91.00	09100	EMERGENCY	3,173	3,173	0	932	900	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,414	23,660	1,015	7,239	3,335	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	262	262	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,870,837	498,154	535,170	298,642	818,133	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	75.816056	20.824095	527.261084	41.254593	245.317241	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	214,826	31,389	59,853	41,963	13,410	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.705868	1.312139	58.968473	5.796795	4.020990	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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:06 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
			14.00	15.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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	289,667			14.00
15.00	01500	PHARMACY	4,587	650,795		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	45,132	9,225		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	39,970	416		50.00
53.00	05300	ANESTHESIOLOGY	4,998	8		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,710	1,957		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	19,569	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	25,752	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	2,002	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	122	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,951	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,318	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	632,101		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	1,088	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3,794	949		90.00
91.00	09100	EMERGENCY	86,672	6,139		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	289,665	650,795		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	452,704	1,050,416		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.562843	1.614051		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33,849	29,053		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.116855	0.044642		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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:06 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	5,086,271		5,086,271	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	953,881		953,881	0	0	50.00
53.00	05300	ANESTHESIOLOGY	7,842		7,842	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,510,764		2,510,764	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,886,958		1,886,958	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	982,382	0	982,382	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	859,521	0	859,521	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,845	0	177,845	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,798	0	14,798	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	87,302		87,302	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,504		79,504	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,788		9,788	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,897,026		1,897,026	0	0	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	91,256		91,256	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	215,886		215,886	0	0	90.00
91.00	09100	EMERGENCY	2,618,015		2,618,015	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	773,351		773,351		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,252,390	0	18,252,390	0	0	200.00
201.00		Less Observation Beds	773,351		773,351		0	201.00
202.00		Total (see instructions)	17,479,039	0	17,479,039	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,862,795		2,862,795			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,283	2,302,186	2,336,469	0.408258	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,022	45,923	46,945	0.167047	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	263,651	6,560,411	6,824,062	0.367928	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	487,328	3,156,432	3,643,760	0.517860	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	371,370	803,857	1,175,227	0.835908	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	0.000000	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	218,475	1,029,516	1,247,991	0.688724	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,292	62,834	141,126	1.260186	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	10,422	0	10,422	1.419881	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	83,509	120,492	204,001	0.427949	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,713	73,969	76,682	1.036801	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	31,163	31,163	0.314090	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,680,199	4,364,109	6,044,308	0.313853	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	3,294	470,080	473,374	0.192778	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,049,296	1,049,296	0.205744	0.000000	90.00
91.00	09100	EMERGENCY	165,529	13,947,179	14,112,708	0.185508	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,850	1,740,029	1,742,879	0.443720	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,265,732	35,757,476	42,023,208			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,265,732	35,757,476	42,023,208			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:06 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03140	CARDIOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:06 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,086,271		5,086,271	0	5,086,271	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	953,881		953,881	0	953,881	50.00
53.00	05300	ANESTHESIOLOGY	7,842		7,842	0	7,842	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,510,764		2,510,764	0	2,510,764	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,886,958		1,886,958	0	1,886,958	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	982,382	0	982,382	0	982,382	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	859,521	0	859,521	0	859,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,845	0	177,845	0	177,845	67.00
68.00	06800	SPEECH PATHOLOGY	14,798	0	14,798	0	14,798	68.00
69.00	06900	ELECTROCARDIOLOGY	87,302		87,302	0	87,302	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,504		79,504	0	79,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,788		9,788	0	9,788	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,897,026		1,897,026	0	1,897,026	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	91,256		91,256	0	91,256	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	215,886		215,886	0	215,886	90.00
91.00	09100	EMERGENCY	2,618,015		2,618,015	0	2,618,015	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	773,351		773,351		773,351	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,252,390	0	18,252,390	0	18,252,390	200.00
201.00		Less Observation Beds	773,351		773,351		773,351	201.00
202.00		Total (see instructions)	17,479,039	0	17,479,039	0	17,479,039	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:06 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,862,795		2,862,795			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,283	2,302,186	2,336,469	0.408258	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,022	45,923	46,945	0.167047	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	263,651	6,560,411	6,824,062	0.367928	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	487,328	3,156,432	3,643,760	0.517860	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	371,370	803,857	1,175,227	0.835908	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	0.000000	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	218,475	1,029,516	1,247,991	0.688724	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,292	62,834	141,126	1.260186	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	10,422	0	10,422	1.419881	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	83,509	120,492	204,001	0.427949	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,713	73,969	76,682	1.036801	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	31,163	31,163	0.314090	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,680,199	4,364,109	6,044,308	0.313853	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	3,294	470,080	473,374	0.192778	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,049,296	1,049,296	0.205744	0.000000	90.00
91.00	09100	EMERGENCY	165,529	13,947,179	14,112,708	0.185508	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,850	1,740,029	1,742,879	0.443720	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,265,732	35,757,476	42,023,208			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,265,732	35,757,476	42,023,208			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:06 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03140	CARDIOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 8:06 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	133,463	2,336,469	0.057122	19,131	1,093	50.00
53.00	05300	ANESTHESIOLOGY	584	46,945	0.012440	534	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,522	6,824,062	0.019859	110,036	2,185	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	62,911	3,643,760	0.017265	207,463	3,582	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	29,043	1,175,227	0.024713	177,556	4,388	65.00
65.01	06501	SLEEP LAB	0	0	0.000000	0	0	65.01
66.00	06600	PHYSICAL THERAPY	82,178	1,247,991	0.065848	37,962	2,500	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,070	141,126	0.057183	9,554	546	67.00
68.00	06800	SPEECH PATHOLOGY	306	10,422	0.029361	3,192	94	68.00
69.00	06900	ELECTROCARDIOLOGY	655	204,001	0.003211	37,932	122	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,429	76,682	0.044717	2,713	121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	423	31,163	0.013574	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,793	6,044,308	0.005756	717,015	4,127	73.00
76.00	03140	CARDIOLOGY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,684	473,374	0.016232	1,520	25	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28,418	1,049,296	0.027083	0	0	90.00
91.00	09100	EMERGENCY	156,063	14,112,708	0.011058	9,547	106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	52,096	1,742,879	0.029891	0	0	92.00
200.00		Total (lines 50 through 199)	735,638	39,160,413		1,334,155	18,896	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:06 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
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
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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:06 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	2,336,469	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	46,945	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,824,062	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	3,643,760	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,175,227	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,247,991	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	141,126	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,422	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	204,001	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	76,682	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	31,163	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,044,308	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	473,374	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,049,296	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	14,112,708	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,742,879	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	39,160,413		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:06 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	19,131	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	534	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	110,036	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	207,463	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	177,556	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	37,962	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	9,554	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,192	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	37,932	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,713	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	717,015	0	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	1,520	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	9,547	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,334,155	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.408258	0	715,177	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.167047	0	15,792	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.367928	0	1,815,605	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.517860	0	909,543	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.835908	0	250,452	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.688724	0	392,583	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.260186	0	19,097	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.419881	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427949	0	50,400	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.036801	0	14,978	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314090	0	9,717	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313853	0	2,609,133	621	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.192778	0	183,735	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.205744	0	538,683	0	0	90.00
91.00	09100	EMERGENCY	0.185508	0	2,952,727	412	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443720	0	586,273	0	0	92.00
200.00		Subtotal (see instructions)		0	11,063,895	1,033	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	11,063,895	1,033	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:06 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	291,977	0		50.00
53.00	05300	ANESTHESIOLOGY	2,638	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,012	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	471,016	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	209,355	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	270,381	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	24,066	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	21,569	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,529	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,052	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	818,884	195		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	35,420	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	110,831	0		90.00
91.00	09100	EMERGENCY	547,754	76		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	260,141	0		92.00
200.00		Subtotal (see instructions)	3,750,625	271		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,750,625	271		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1302 | Component CCN: 15-Z302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:06 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	0.408258	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.167047	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.367928	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.517860	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.835908	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.688724	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.260186	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.419881	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427949	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.036801	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314090	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313853	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.192778	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.205744	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.185508	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443720	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: 15-1302 | Component CCN: 15-Z302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 8:06 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:06 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)	2,389	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,352	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,015	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	855	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	182	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)	628	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)	855	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)	5,086,271	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)	21,640	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)	1,983,694	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,102,577	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,102,577	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)	2,294.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,441,134	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,441,134	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:06 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						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)	593,105	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,034,239	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)	1,962,054	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)	1,962,054	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)	337	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,294.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	773,351	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:06 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	342,633	5,086,271	0.067364	773,351	52,096	90.00
91.00	Nursing School cost	0	5,086,271	0.000000	773,351	0	91.00
92.00	Allied health cost	0	5,086,271	0.000000	773,351	0	92.00
93.00	All other Medical Education	0	5,086,271	0.000000	773,351	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:06 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)	2,389	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,352	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,015	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	855	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	182	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)	10	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)	5,086,271	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)	21,640	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)	1,983,694	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,102,577	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,102,577	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)	2,294.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	22,948	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)	22,948	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:06 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						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)	12,172	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	35,120	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)	337	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,294.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	773,351	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:06 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	342,633	5,086,271	0.067364	773,351	52,096	90.00
91.00	Nursing School cost	0	5,086,271	0.000000	773,351	0	91.00
92.00	Allied health cost	0	5,086,271	0.000000	773,351	0	92.00
93.00	All other Medical Education	0	5,086,271	0.000000	773,351	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:06 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		1,216,484		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.408258	19,131	7,810	50.00
53.00	05300	ANESTHESIOLOGY	0.167047	534	89	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.367928	110,036	40,485	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.517860	207,463	107,437	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.835908	177,556	148,420	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.688724	37,962	26,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.260186	9,554	12,040	67.00
68.00	06800	SPEECH PATHOLOGY	1.419881	3,192	4,532	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427949	37,932	16,233	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.036801	2,713	2,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314090	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313853	717,015	225,037	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.192778	1,520	293	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.205744	0	0	90.00
91.00	09100	EMERGENCY	0.185508	9,547	1,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443720	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,334,155	593,105	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,334,155		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1302 | Component CCN: 15-Z302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:06 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.408258	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.167047	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.367928	50,387	18,539	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.517860	131,730	68,218	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.835908	87,781	73,377	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.688724	144,027	99,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.260186	60,973	76,837	67.00
68.00	06800	SPEECH PATHOLOGY	1.419881	6,166	8,755	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427949	23,562	10,083	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.036801	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314090	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313853	557,299	174,910	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.192778	1,769	341	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.205744	0	0	90.00
91.00	09100	EMERGENCY	0.185508	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443720	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,063,694	530,255	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,063,694		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:06 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		18,776		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.408258	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.167047	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.367928	8,218	3,024	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.517860	4,577	2,370	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.835908	2,834	2,369	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.688724	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.260186	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.419881	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427949	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.036801	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314090	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313853	7,384	2,317	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.192778	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.205744	0	0	90.00
91.00	09100	EMERGENCY	0.185508	11,278	2,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443720	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		34,291	12,172	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)		34,291		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1302 | Component CCN: 15-Z302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:06 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.408258	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.167047	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.367928	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.517860	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.835908	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.688724	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.260186	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.419881	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427949	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.036801	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314090	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313853	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.192778	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.205744	0	0	90.00
91.00	09100	EMERGENCY	0.185508	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443720	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: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 8:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,750,896	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)	3,750,896	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)	3,788,405	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)	30,620	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,991,647	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)	1,766,138	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)	1,766,138	30.00
31.00	Primary payer payments	137	31.00
32.00	Subtotal (line 30 minus line 31)	1,766,001	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)	397,605	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	258,443	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	297,069	36.00
37.00	Subtotal (see instructions)	2,024,444	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,024,444	40.00
40.01	Sequestration adjustment (see instructions)	40,489	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,158,171	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)	-174,216	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	172,265	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: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 6/29/2020 8:06 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		1,611,332		2,158,171	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)		1,611,332		2,158,171	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		246,637		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		174,216	6.02
7.00	Total Medicare program liability (see instructions)		1,857,969		1,983,955	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: 15-1302 | Component CCN: 15-Z302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/29/2020 8:06 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		2,253,893		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	07/23/2019	57,500		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)		57,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,311,393		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		134,077		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,445,470		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: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/29/2020 8:06 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: 15-1302 Component CCN: 15-Z302	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2 Date/Time Prepared: 6/29/2020 8:06 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)	1,981,675	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)	535,558	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	855	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)	2,517,233	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,517,233	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)	2,517,233	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	23,332	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,493,901	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)	2,272	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,477	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,495,378	0	19.00
19.01	Sequestration adjustment (see instructions)	49,908	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	2,311,393	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)	134,077	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	57,908	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: 15-1302 | Component CCN: 15-Z302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 6/29/2020 8:06 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: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 8:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,034,239	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,034,239	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,054,581	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,054,581	19.00
20.00	Deductibles (exclude professional component)	177,320	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,877,261	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,877,261	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,655	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,626	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	17,249	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,895,887	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)	1,895,887	30.00
30.01	Sequestration adjustment (see instructions)	37,918	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,611,332	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)	246,637	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	50,145	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/29/2020 8:06 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	3,615,206	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,928,080	0	0	0	4.00
5.00	Other receivable	-1,020,607	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	245,169	0	0	0	7.00
8.00	Prepaid expenses	67,664	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,835,512	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	190,324	0	0	0	12.00
13.00	Land improvements	259,436	0	0	0	13.00
14.00	Accumulated depreciation	-256,050	0	0	0	14.00
15.00	Buildings	15,007,745	0	0	0	15.00
16.00	Accumulated depreciation	-9,338,613	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,530,274	0	0	0	23.00
24.00	Accumulated depreciation	-3,126,305	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,266,811	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,102,323	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	316,615	0	0	0	37.00
38.00	Salaries, wages, and fees payable	474,933	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,835,700	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,627,248	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	18,774	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,774	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,646,022	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,456,301				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)	9,456,301	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,102,323	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/29/2020 8:06 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		10,924,217		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,467,917				2.00
3.00	Total (sum of line 1 and line 2)		9,456,300		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		9,456,301		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,456,301		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1302 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/29/2020 8:06 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,019,166		2,019,166	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	847,029		847,029	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,866,195		2,866,195	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,866,195		2,866,195	17.00
18.00	Ancillary services	3,234,557	19,020,973	22,255,530	18.00
19.00	Outpatient services	168,379	16,733,104	16,901,483	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	72,177	72,177	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,269,131	35,826,254	42,095,385	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,675,824		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)		18,675,824		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 6/29/2020 8:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	42,095,385	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,290,274	2.00
3.00	Net patient revenues (line 1 minus line 2)	16,805,111	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,675,824	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,870,713	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	402,796	24.00
25.00	Total other income (sum of lines 6-24)	402,796	25.00
26.00	Total (line 5 plus line 25)	-1,467,917	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)	-1,467,917	29.00