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: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 9:03 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/29/2020 Time: 9:03 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 PAOLI HOSPITAL (15-1306) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MICHAEL CRAIG
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-43,046	-126,461	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	-23,695	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-66,741	-126,461	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 9:03 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 642 WEST HOSPITAL ROAD	PO Box:			1.00
2.00	City: PAOLI	State: IN	Zip Code: 47454	County: ORANGE	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 PAOLI HOSPITAL	151306	99915	1	07/01/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IUHP SWING BEDS	15Z306	99915		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 9:03 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

		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

		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

			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.	Y		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

		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:	41,203	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 9:03 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH 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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		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	4	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/29/2020 9:03 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	03/20/2020	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/29/2020 9:03 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.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 6/29/2020 9:03 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	24	8,760	16,656.00	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)		24	8,760	16,656.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		24	8,760	16,656.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 9:03 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)	223	20	694			1.00
2.00	HMO and other (see instructions)	71	314				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	116	0	116			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	152			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	339	20	962			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		29	215			13.00
14.00	Total (see instructions)	339	49	1,177	0.00	126.45	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			16			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	126.45	27.00
28.00	Observation Bed Days		15	665			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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 6/29/2020 9:03 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	88	9	261	1.00
2.00	HMO and other (see instructions)			26	125		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	88	9	261	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 6/29/2020 9:03 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)	0.360007	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,229,311	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	16,545,536	6.00
7.00	Medicaid cost (line 1 times line 6)	5,956,509	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)	2,727,198	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)	271	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	1,257	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	453	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)	182	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)	2,727,380	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)	1,887,074	88,686	1,975,760	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	679,360	88,686	768,046	21.00
22.00	Payments received from patients for amounts previously written off as charity care	3,570	0	3,570	22.00
23.00	Cost of charity care (line 21 minus line 22)	675,790	88,686	764,476	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,633,369	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	874,654	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,345,622	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,287,747	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,294,573	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,059,049	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,786,429	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	547,557	547,557	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,123,585	1,123,585	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	54,381	187,412	241,793	1,367,329	1,609,122	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	437,647	6,326,161	6,763,808	-288,871	6,474,937	5.00
7.00	00700	OPERATION OF PLANT	414,165	1,352,811	1,766,976	-711,237	1,055,739	7.00
7.01	00701	UTILITIES	0	0	0	359,967	359,967	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,499	63,499	0	63,499	8.00
9.00	00900	HOUSEKEEPING	192,149	138,329	330,478	-82,213	248,265	9.00
10.00	01000	DIETARY	188,888	145,403	334,291	-243,192	91,099	10.00
11.00	01100	CAFETERIA	0	0	0	174,166	174,166	11.00
13.00	01300	NURSING ADMINISTRATION	589,990	839,138	1,429,128	-176,855	1,252,273	13.00
13.01	01301	HOUSE SUPERVISORS	382,577	91,079	473,656	-62,650	411,006	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,213	36,213	362,148	398,361	14.00
15.00	01500	PHARMACY	228,481	1,860,151	2,088,632	-1,585,062	503,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,486	12,486	-3,838	8,648	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	341,058	68,393	409,451	-37,066	372,385	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,009,626	1,073,332	2,082,958	-382,061	1,700,897	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	90,640	17,893	108,533	-46,858	61,675	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	441,478	407,932	849,410	-333,754	515,656	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,483	0	57,483	32,031	89,514	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	843,723	1,152,890	1,996,613	-735,258	1,261,355	54.00
60.00	06000	LABORATORY	340	1,656,130	1,656,470	-1,568	1,654,902	60.00
64.00	06400	INTRAVENOUS THERAPY	63,892	37,098	100,990	-24,247	76,743	64.00
65.00	06500	RESPIRATORY THERAPY	329,533	164,208	493,741	-110,627	383,114	65.00
66.00	06600	PHYSICAL THERAPY	494,979	293,211	788,190	-396,190	392,000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	89,271	89,271	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	58,845	58,845	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,900	25,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,169	20,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,509,068	1,509,068	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	537	3,837	4,374	-4,374	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	42,809	27,956	70,765	-1,729	69,036	90.00
90.01	09001	VISITING SPECIALTY CLINIC	191,071	71,680	262,751	-34,907	227,844	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	1	1	-1	0	90.02
91.00	09100	EMERGENCY	1,230,083	1,763,707	2,993,790	-398,939	2,594,851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,625,530	17,790,950	25,416,480	8,539	25,425,019	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	1,230	1,230	-1,000	230	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	5,215	5,215	-1,621	3,594	190.05
190.06	19006	OTHER PROPERTY	0	5,948	5,948	-5,918	30	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,625,530	17,803,343	25,428,873	0	25,428,873	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,400	545,157	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,123,585	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	262,883	1,872,005	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-206,212	6,268,725	5.00
7.00	00700	OPERATION OF PLANT	-24,191	1,031,548	7.00
7.01	00701	UTILITIES	0	359,967	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,499	8.00
9.00	00900	HOUSEKEEPING	0	248,265	9.00
10.00	01000	DIETARY	0	91,099	10.00
11.00	01100	CAFETERIA	-81,018	93,148	11.00
13.00	01300	NURSING ADMINISTRATION	-655,451	596,822	13.00
13.01	01301	HOUSE SUPERVISORS	0	411,006	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	398,361	14.00
15.00	01500	PHARMACY	-47,437	456,133	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,327	4,321	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-88,503	283,882	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-472,015	1,228,882	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	61,675	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-2,000	513,656	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	89,514	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-730	1,260,625	54.00
60.00	06000	LABORATORY	0	1,654,902	60.00
64.00	06400	INTRAVENOUS THERAPY	0	76,743	64.00
65.00	06500	RESPIRATORY THERAPY	0	383,114	65.00
66.00	06600	PHYSICAL THERAPY	138,720	530,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	89,271	67.00
68.00	06800	SPEECH PATHOLOGY	0	58,845	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	774	1,509,842	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	18,501	87,537	90.00
90.01	09001	VISITING SPECIALTY CLINIC	-213	227,631	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	90.02
91.00	09100	EMERGENCY	-332,325	2,262,526	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,495,944	23,929,075	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	190.01
190.02	19002	OUTREACH	0	230	190.02
190.03	19003	FOUNDATION	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	3,594	190.05
190.06	19006	OTHER PROPERTY	0	30	190.06
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,495,944	23,932,929	200.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 9:03 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,368,132	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	0		0	1,368,132	
	B - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,509,068	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
	0		0	1,509,068	
	C - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	25,900	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
	0		0	25,900	
	D - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	20,169	1.00
2.00		0.00	0	0	2.00
	0		0	20,169	
	E - NON-BILLABLE DRUGS				
1.00	PHARMACY	15.00	0	15,828	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
	0		0	15,828	
	F - NON-BILLABLE MED SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	364,858	1.00
2.00	CARDIAC REHABILITATION	76.97	0	12	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	0		0	364,870	
	G - CAPITAL RELATED COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	377,978	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,123,585	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	1,501,563	
	H - LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169,579	1.00
	0		0	169,579	
	I - COO/CNO				
1.00	ADMINISTRATIVE & GENERAL	5.00	103,164	0	1.00
	0		103,164	0	
	J - UTILITIES				
1.00	UTILITIES	7.01	0	359,967	1.00
	0		0	359,967	
	L - OBSTETRICS				
1.00	ADULTS & PEDIATRICS	30.00	12,831	0	1.00
2.00	NURSERY	43.00	0	6,076	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	22,619	9,412	3.00
	0		35,450	15,488	
	M - CAFETERIA				
1.00	CAFETERIA	11.00	124,019	50,147	1.00
	0		124,019	50,147	
	N - OT AND ST				
1.00	OCCUPATIONAL THERAPY	67.00	81,367	7,325	1.00
2.00	SPEECH PATHOLOGY	68.00	53,985	4,860	2.00
	0		135,352	12,185	
	O - CARDIAC REHAB				
1.00	OCCUPATIONAL THERAPY	67.00	537	42	1.00
	TOTALS		537	42	
500.00	Grand Total: Increases		398,522	5,412,938	500.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 9:03 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	44,539	0	1.00
2.00	OPERATION OF PLANT	7.00	0	64,376	0	2.00
3.00	HOUSEKEEPING	9.00	0	71,718	0	3.00
4.00	DIETARY	10.00	0	61,953	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	73,262	0	5.00
6.00	HOUSE SUPERVISORS	13.01	0	62,650	0	6.00
7.00	PHARMACY	15.00	0	57,569	0	7.00
8.00	NONPHYSICIAN ANESTHETISTS	19.00	0	25,309	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	275,302	0	9.00
10.00	OPERATING ROOM	50.00	0	97,520	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	122,384	0	11.00
12.00	LABORATORY	60.00	0	5	0	12.00
13.00	INTRAVENOUS THERAPY	64.00	0	14,317	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	46,317	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	88,379	0	15.00
16.00	CARDIAC REHABILITATION	76.97	0	22	0	16.00
17.00	CLINIC	90.00	0	1,729	0	17.00
18.00	VISITING SPECIALTY CLINIC	90.01	0	26,216	0	18.00
19.00	PAOLI PRIMARY CARE CLINIC	90.02	0	1	0	19.00
20.00	EMERGENCY	91.00	0	234,564	0	20.00
	0		0	1,368,132		
	B - BILLABLE DRUGS					
1.00	DIETARY	10.00		31	0	1.00
2.00	PHARMACY	15.00		1,482,640	0	2.00
3.00	ADULTS & PEDIATRICS	30.00		73	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		25,712	0	4.00
5.00	VISITING SPECIALTY CLINIC	90.01		612	0	5.00
	0		0	1,509,068		
	C - BILLABLE SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	200	0	1.00
2.00	PHARMACY	15.00	0	28	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	378	0	3.00
4.00	NURSERY	43.00	0	22	0	4.00
5.00	OPERATING ROOM	50.00	0	18,110	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	283	0	6.00
7.00	VISITING SPECIALTY CLINIC	90.01	0	1,676	0	7.00
8.00	EMERGENCY	91.00	0	5,203	0	8.00
	0		0	25,900		
	D - IMPLANT SUPPLIES					
1.00	OPERATING ROOM	50.00		19,946	0	1.00
2.00	EMERGENCY	91.00		223	0	2.00
	0		0	20,169		
	E - NON-BILLABLE DRUGS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	104	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,892	0	2.00
3.00	NURSERY	43.00	0	107	0	3.00
4.00	OPERATING ROOM	50.00	0	2,357	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,912	0	5.00
6.00	INTRAVENOUS THERAPY	64.00	0	703	0	6.00
7.00	PHYSICAL THERAPY	66.00	0	37	0	7.00
8.00	EMERGENCY	91.00	0	6,716	0	8.00
	0		0	15,828		
	F - NON-BILLABLE MED SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	556	0	1.00
2.00	OPERATION OF PLANT	7.00	0	1,292	0	2.00
3.00	HOUSEKEEPING	9.00	0	10,335	0	3.00
4.00	DIETARY	10.00	0	360	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	2	0	5.00
6.00	PHARMACY	15.00	0	28,583	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	1	0	7.00
8.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,276	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	44,722	0	9.00
10.00	NURSERY	43.00	0	15,458	0	10.00
11.00	OPERATING ROOM	50.00	0	53,567	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,057	0	12.00
13.00	INTRAVENOUS THERAPY	64.00	0	8,234	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	39,242	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	8,219	0	15.00
16.00	VISITING SPECIALTY CLINIC	90.01	0	4,099	0	16.00
17.00	EMERGENCY	91.00	0	110,098	0	17.00
18.00	OUTREACH	190.02	0	769	0	18.00
	0		0	364,870		

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 9:03 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	G - CAPITAL RELATED COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	803	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	177,361	9	2.00
3.00	OPERATION OF PLANT	7.00	0	285,602	0	3.00
4.00	HOUSEKEEPING	9.00	0	160	0	4.00
5.00	DIETARY	10.00	0	6,682	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	427	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,406	0	7.00
8.00	PHARMACY	15.00	0	32,070	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,837	0	9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	9,481	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	56,037	0	11.00
12.00	NURSERY	43.00	0	1,897	0	12.00
13.00	OPERATING ROOM	50.00	0	142,254	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	547,193	0	14.00
15.00	LABORATORY	60.00	0	1,563	0	15.00
16.00	INTRAVENOUS THERAPY	64.00	0	993	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	25,068	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	151,735	0	18.00
19.00	CARDIAC REHABILITATION	76.97	0	3,785	0	19.00
20.00	VISITING SPECIALTY CLINIC	90.01	0	2,304	0	20.00
21.00	EMERGENCY	91.00	0	42,135	0	21.00
22.00	OUTREACH	190.02	0	231	0	22.00
23.00	PAOLI FAMILY PRACTICE	190.05	0	1,621	0	23.00
24.00	OTHER PROPERTY	190.06	0	5,918	0	24.00
	0		0	1,501,563		
	H - LEASE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	169,579	10	1.00
	0		0	169,579		
	I - COO/CNO					
1.00	NURSING ADMINISTRATION	13.00	103,164	0	0	1.00
	0		103,164	0		
	J - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	359,967	0	1.00
	0		0	359,967		
	L - OBSTETRICS					
1.00	ADULTS & PEDIATRICS	30.00	0	15,488	0	1.00
2.00	NURSERY	43.00	35,450	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		35,450	15,488		
	M - CAFETERIA					
1.00	DIETARY	10.00	124,019	50,147	0	1.00
	0		124,019	50,147		
	N - OT AND ST					
1.00	PHYSICAL THERAPY	66.00	135,352	12,185	0	1.00
2.00		0.00	0	0	0	2.00
	0		135,352	12,185		
	O - CARDIAC REHAB					
1.00	CARDIAC REHABILITATION	76.97	537	42	0	1.00
	TOTALS		537	42		
500.00	Grand Total: Decreases		398,522	5,412,938		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 6/29/2020 9:03 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	148,000	0	0	0	0	1.00
2.00	Land Improvements	438,464	0	0	0	0	2.00
3.00	Buildings and Fixtures	4,741,722	0	0	0	0	3.00
4.00	Building Improvements	1,786,121	153,618	0	153,618	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,877,540	1,992,160	0	1,992,160	535,046	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,991,847	2,145,778	0	2,145,778	535,046	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,991,847	2,145,778	0	2,145,778	535,046	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	148,000	0	1.00
2.00	Land Improvements	438,464	0	2.00
3.00	Buildings and Fixtures	4,741,722	0	3.00
4.00	Building Improvements	1,939,739	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,334,654	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,602,579	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	18,602,579	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II Date/Time Prepared: 6/29/2020 9:03 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1306

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

Worksheet A-7 Part III
Date/Time Prepared: 6/29/2020 9:03 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,267,926	0	7,267,926	0.390695	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,334,653	0	11,334,653	0.609305	0	2.00
3.00	Total (sum of lines 1-2)	18,602,579	0	18,602,579	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	675,860	-130,703	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,123,585	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,799,445	-130,703	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	545,157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,123,585	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,668,742	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 9:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-300,282	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,371,522			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	3,810,952			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-151,803	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	4,511	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 9:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-1,303	OPERATION OF PLANT	7.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-81,018	CAFETERIA	11.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	1,000	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-4,327	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-2,000	OPERATING ROOM	50.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-12,261	PHYSICAL THERAPY	66.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	774	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-213	VISITING SPECIALTY CLINIC	90.01	0	33.08
33.09	HAF	A	-873,214	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ACCRUED PTO	A	-54,381	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	BENEFITS	A	-1,371,624	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	CRNA	A	-88,503	NONPHYSICIAN ANESTHETISTS	19.00	0	33.12
33.13	MARKETING	A	-730	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,495,944				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: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/29/2020 9:03 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	297,882	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	151,803	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,730,366	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,107,938	3,814,017	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	205,353	0	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	85,801	127,279	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,189,924	878,620	3.04
3.05	7.00	OPERATION OF PLANT	RELATED PARTY	0	22,888	3.05
3.06	13.00	NURSING ADMINISTRATION	RELATED PARTY	45,627	702,078	3.06
3.07	15.00	PHARMACY	RELATED PARTY	162,311	209,748	3.07
3.09	66.00	PHYSICAL THERAPY	RELATED PARTY	150,981	0	3.09
3.10	90.00	CLINIC	RELATED PARTY	41,430	22,929	3.10
3.11	91.00	EMERGENCY	SIP ER ALLOCATION	2,653,571	1,234,476	3.11
3.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	574	574	3.12
3.13	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	161,068	161,068	3.13
3.14	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	44,140	44,140	3.14
3.15	60.00	LABORATORY	SHARED EMPLOYEES	1,581,220	1,581,220	3.15
3.16	65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES	19,078	19,078	3.16
4.00	90.01	VISITING SPECIALTY CLINIC	SHARED EMPLOYEES	62,791	62,791	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,691,858	8,880,906	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	IU HEALTH BLOOM	0.00	6.00
7.00	B		0.00	IU HEALTH	100.00	7.00
8.00	C		0.00	IUH SIP	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 9:03 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	297,882	9	1.00
2.00	151,803	9	2.00
3.00	1,730,366	0	3.00
3.01	293,921	0	3.01
3.02	205,353	9	3.02
3.03	-41,478	0	3.03
3.04	311,304	0	3.04
3.05	-22,888	0	3.05
3.06	-656,451	0	3.06
3.07	-47,437	0	3.07
3.09	150,981	0	3.09
3.10	18,501	0	3.10
3.11	1,419,095	0	3.11
3.12	0	0	3.12
3.13	0	0	3.13
3.14	0	0	3.14
3.15	0	0	3.15
3.16	0	0	3.16
4.00	0	0	4.00
5.00	3,810,952		5.00

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

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

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

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

6.00	HOSPITAL	6.00
7.00	HOME OFFICE	7.00
8.00	PHYSICIAN GROUP	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/29/2020 9:03 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	148,087	148,087	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	569,513	472,015	97,498	0	0	2.00
3.00	91.00	EMERGENCY	2,468,633	1,751,420	717,213	0	0	3.00
4.00	0.00		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			3,186,233	2,371,522	814,711		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	148,087	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	472,015	2.00
3.00	91.00	EMERGENCY	0	0	0	1,751,420	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2,371,522	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	545,157	545,157				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,123,585		1,123,585			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,872,005	9,722	21,249	1,902,976		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,268,725	33,399	72,994	135,931	6,511,049	5.00
7.00	00700	OPERATION OF PLANT	1,031,548	41,995	91,780	104,099	1,269,422	7.00
7.01	00701	UTILITIES	359,967	0	0	0	359,967	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	63,499	2,840	6,207	0	72,546	8.00
9.00	00900	HOUSEKEEPING	248,265	8,975	19,614	48,296	325,150	9.00
10.00	01000	DIETARY	91,099	16,453	35,959	16,305	159,816	10.00
11.00	01100	CAFETERIA	93,148	9,514	20,793	31,172	154,627	11.00
13.00	01300	NURSING ADMINISTRATION	596,822	13,263	28,987	122,362	761,434	13.00
13.01	01301	HOUSE SUPERVISORS	411,006	0	0	96,159	507,165	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	398,361	19,805	43,283	0	461,449	14.00
15.00	01500	PHARMACY	456,133	11,067	24,186	57,428	548,814	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,321	7,129	15,579	0	27,029	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	283,882	0	0	85,724	369,606	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,228,882	73,375	160,370	256,990	1,719,617	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	61,675	2,367	5,172	13,872	83,086	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	513,656	57,057	124,698	110,964	806,375	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,514	2,092	4,572	20,133	116,311	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,260,625	54,595	119,319	212,066	1,646,605	54.00
60.00	06000	LABORATORY	1,654,902	16,103	35,193	85	1,706,283	60.00
64.00	06400	INTRAVENOUS THERAPY	76,743	4,260	9,310	16,059	106,372	64.00
65.00	06500	RESPIRATORY THERAPY	383,114	2,689	5,876	82,827	474,506	65.00
66.00	06600	PHYSICAL THERAPY	530,720	38,464	84,063	90,391	743,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,271	8,700	19,014	20,586	137,571	67.00
68.00	06800	SPEECH PATHOLOGY	58,845	5,775	12,621	13,569	90,810	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,900	0	0	0	25,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,169	0	0	0	20,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,509,842	0	0	0	1,509,842	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	87,537	360	786	10,760	99,443	90.00
90.01	09001	VISITING SPECIALTY CLINIC	227,631	35,501	77,587	48,025	388,744	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,262,526	38,606	84,373	309,173	2,694,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,929,075	514,106	1,123,585	1,902,976	23,898,024	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	230	4,241	0	0	4,471	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	3,594	0	0	0	3,594	190.05
190.06	19006	OTHER PROPERTY	30	26,810	0	0	26,840	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	23,932,929	545,157	1,123,585	1,902,976	23,932,929	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,511,049					5.00
7.00	00700	OPERATION OF PLANT	474,419	1,743,841				7.00
7.01	00701	UTILITIES	134,530	0	494,497			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	27,112	13,104	3,081	115,843		8.00
9.00	00900	HOUSEKEEPING	121,518	41,409	9,736	0	497,813	9.00
10.00	01000	DIETARY	59,728	75,916	17,850	0	20,972	10.00
11.00	01100	CAFETERIA	57,788	43,899	10,322	0	12,127	11.00
13.00	01300	NURSING ADMINISTRATION	284,569	61,196	14,389	0	16,906	13.00
13.01	01301	HOUSE SUPERVISORS	189,542	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	172,456	91,379	21,486	0	0	14.00
15.00	01500	PHARMACY	205,107	51,062	12,006	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,101	32,891	7,734	0	9,086	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	138,132	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	642,669	338,565	79,608	30,903	93,532	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	31,052	10,920	2,568	0	3,017	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	301,365	263,260	61,901	8,388	72,728	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,469	9,653	2,270	1,833	2,667	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	615,382	251,903	59,230	20,578	69,591	54.00
60.00	06000	LABORATORY	637,686	74,300	17,470	0	20,526	60.00
64.00	06400	INTRAVENOUS THERAPY	39,754	19,656	4,622	0	5,430	64.00
65.00	06500	RESPIRATORY THERAPY	177,336	12,405	2,917	0	3,427	65.00
66.00	06600	PHYSICAL THERAPY	277,918	6,334	41,729	3,521	49,028	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,414	1,441	9,439	797	11,090	67.00
68.00	06800	SPEECH PATHOLOGY	33,938	961	6,265	528	7,361	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,680	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,538	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	564,270	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	37,165	1,660	390	0	459	90.00
90.01	09001	VISITING SPECIALTY CLINIC	145,285	163,800	38,515	1,460	45,251	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,007,081	178,127	41,883	47,835	49,209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,498,004	1,743,841	465,411	115,843	492,407	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	1,671	0	0	0	5,406	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	1,343	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	10,031	0	29,086	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	6,511,049	1,743,841	494,497	115,843	497,813	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	HOUSE SUPERVISORS	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	13.01	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	334,282					10.00
11.00	01100	CAFETERIA	0	278,763				11.00
13.00	01300	NURSING ADMINISTRATION	0	16,439	1,154,933			13.00
13.01	01301	HOUSE SUPERVISORS	0	12,816	0	709,523		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	746,770	14.00
15.00	01500	PHARMACY	0	10,657	425	261	53,726	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	5,432	0	0	4,148	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	334,282	46,790	461,434	283,479	82,532	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,985	20,870	12,821	29,306	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,887	138,513	85,094	114,167	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,881	30,282	18,604	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,146	14,860	9,129	68,148	54.00
60.00	06000	LABORATORY	0	33,000	412	253	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,180	22,914	14,077	15,028	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,167	0	0	70,621	65.00
66.00	06600	PHYSICAL THERAPY	0	14,565	0	0	11,185	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,322	0	0	2,530	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,186	0	0	1,679	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	46,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	35,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	888	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	8,983	49,574	30,455	7,468	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	53,439	415,649	255,350	202,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	334,282	278,763	1,154,933	709,523	745,344	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	1,426	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	334,282	278,763	1,154,933	709,523	746,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	HOUSE SUPERVISORS						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	882,058					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	86,843				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	517,318		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,673	8,006	0	0	4,123,090	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	62	412	0	0	196,099	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,363	7,139	0	517,318	2,393,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,423	0	0	229,393	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,685	16,035	0	0	2,806,292	54.00
60.00	06000	LABORATORY	0	7,782	0	0	2,497,712	60.00
64.00	06400	INTRAVENOUS THERAPY	407	2,254	0	0	232,694	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,690	0	0	757,069	65.00
66.00	06600	PHYSICAL THERAPY	16	2,016	0	0	1,149,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	3	455	0	0	218,062	67.00
68.00	06800	SPEECH PATHOLOGY	2	265	0	0	143,995	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	201	0	0	81,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	123	0	0	63,812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,962	11,004	0	0	2,958,078	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	84	0	0	140,089	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	865	0	0	880,400	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,885	27,089	0	0	4,976,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	882,058	86,843	0	517,318	23,849,061	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	12,974	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	4,937	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	65,957	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	882,058	86,843	0	517,318	23,932,929	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	UTILITIES			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
13.01	01301	HOUSE SUPERVISORS			13.01
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	4,123,090	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	196,099	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	2,393,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	229,393	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,806,292	54.00
60.00	06000	LABORATORY	0	2,497,712	60.00
64.00	06400	INTRAVENOUS THERAPY	0	232,694	64.00
65.00	06500	RESPIRATORY THERAPY	0	757,069	65.00
66.00	06600	PHYSICAL THERAPY	0	1,149,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	218,062	67.00
68.00	06800	SPEECH PATHOLOGY	0	143,995	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	63,812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,958,078	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	140,089	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	880,400	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	90.02
91.00	09100	EMERGENCY	0	4,976,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	23,849,061	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	190.01
190.02	19002	OUTREACH	0	12,974	190.02
190.03	19003	FOUNDATION	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	4,937	190.05
190.06	19006	OTHER PROPERTY	0	65,957	190.06
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	23,932,929	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,722	21,249	30,971	30,971	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	205,353	33,399	72,994	311,746	2,212	5.00
7.00	00700	OPERATION OF PLANT	0	41,995	91,780	133,775	1,694	7.00
7.01	00701	UTILITIES	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,840	6,207	9,047	0	8.00
9.00	00900	HOUSEKEEPING	0	8,975	19,614	28,589	786	9.00
10.00	01000	DIETARY	0	16,453	35,959	52,412	265	10.00
11.00	01100	CAFETERIA	0	9,514	20,793	30,307	507	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,263	28,987	42,250	1,992	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	0	0	1,565	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,805	43,283	63,088	0	14.00
15.00	01500	PHARMACY	0	11,067	24,186	35,253	935	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,129	15,579	22,708	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,395	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	73,375	160,370	233,745	4,183	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,367	5,172	7,539	226	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	57,057	124,698	181,755	1,806	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,092	4,572	6,664	328	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,595	119,319	173,914	3,452	54.00
60.00	06000	LABORATORY	0	16,103	35,193	51,296	1	60.00
64.00	06400	INTRAVENOUS THERAPY	0	4,260	9,310	13,570	261	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,689	5,876	8,565	1,348	65.00
66.00	06600	PHYSICAL THERAPY	0	38,464	84,063	122,527	1,471	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,700	19,014	27,714	335	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,775	12,621	18,396	221	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	360	786	1,146	175	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	35,501	77,587	113,088	782	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	38,606	84,373	122,979	5,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	205,353	514,106	1,123,585	1,843,044	30,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	4,241	0	4,241	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	26,810	0	26,810	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	205,353	545,157	1,123,585	1,874,095	30,971	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	313,958					5.00
7.00	00700	OPERATION OF PLANT	22,876	158,345				7.00
7.01	00701	UTILITIES	6,487	0	6,487			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,307	1,190	40	11,584		8.00
9.00	00900	HOUSEKEEPING	5,860	3,760	128	0	39,123	9.00
10.00	01000	DIETARY	2,880	6,893	234	0	1,648	10.00
11.00	01100	CAFETERIA	2,787	3,986	135	0	953	11.00
13.00	01300	NURSING ADMINISTRATION	13,722	5,557	189	0	1,329	13.00
13.01	01301	HOUSE SUPERVISORS	9,140	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	8,316	8,297	282	0	0	14.00
15.00	01500	PHARMACY	9,890	4,637	158	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	487	2,987	101	0	714	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,661	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,989	30,742	1,045	3,090	7,351	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,497	992	34	0	237	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,532	23,905	812	839	5,716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,096	877	30	183	210	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,673	22,873	777	2,058	5,469	54.00
60.00	06000	LABORATORY	30,749	6,747	229	0	1,613	60.00
64.00	06400	INTRAVENOUS THERAPY	1,917	1,785	61	0	427	64.00
65.00	06500	RESPIRATORY THERAPY	8,551	1,126	38	0	269	65.00
66.00	06600	PHYSICAL THERAPY	13,401	575	547	352	3,853	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,479	131	124	80	872	67.00
68.00	06800	SPEECH PATHOLOGY	1,636	87	82	53	578	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	467	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	363	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,209	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,792	151	5	0	36	90.00
90.01	09001	VISITING SPECIALTY CLINIC	7,006	14,873	505	146	3,556	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	48,558	16,174	549	4,783	3,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	313,328	158,345	6,105	11,584	38,698	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	81	0	0	0	425	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	65	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	484	0	382	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	313,958	158,345	6,487	11,584	39,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	HOUSE SUPERVISORS	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	13.01	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	64,332					10.00
11.00	01100	CAFETERIA	0	38,675				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,281	67,320			13.00
13.01	01301	HOUSE SUPERVISORS	0	1,778	0	12,483		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	79,983	14.00
15.00	01500	PHARMACY	0	1,479	25	5	5,754	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	754	0	0	444	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,332	6,492	26,896	4,986	8,840	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	275	1,216	226	3,139	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,204	8,074	1,497	12,228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	400	1,765	327	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,599	866	161	7,299	54.00
60.00	06000	LABORATORY	0	4,578	24	4	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	302	1,336	248	1,610	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,965	0	0	7,564	65.00
66.00	06600	PHYSICAL THERAPY	0	2,021	0	0	1,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	461	0	0	271	67.00
68.00	06800	SPEECH PATHOLOGY	0	303	0	0	180	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	123	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,246	2,890	536	800	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	7,414	24,228	4,493	21,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,332	38,675	67,320	12,483	79,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	153	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	64,332	38,675	67,320	12,483	79,983	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	HOUSE SUPERVISORS						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	58,136					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,997				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	9,254		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110	2,492	0		425,293	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	4	128	0		15,513	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	90	2,222	0		255,680	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	443	0		13,323	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111	4,990	0		256,242	54.00
60.00	06000	LABORATORY	0	2,422	0		97,663	60.00
64.00	06400	INTRAVENOUS THERAPY	27	701	0		22,245	64.00
65.00	06500	RESPIRATORY THERAPY	0	526	0		29,952	65.00
66.00	06600	PHYSICAL THERAPY	1	627	0		146,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	142	0		32,609	67.00
68.00	06800	SPEECH PATHOLOGY	0	82	0		21,618	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62	0		5,478	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38	0		4,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,537	3,425	0		88,171	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0		0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0		0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90.00	09000	CLINIC	0	26	0		3,454	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	269	0		145,697	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0		0	90.02
91.00	09100	EMERGENCY	256	8,402	0		268,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,136	26,997	0	0	1,832,200	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0		0	190.01
190.02	19002	OUTREACH	0	0	0		4,900	190.02
190.03	19003	FOUNDATION	0	0	0		0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0		0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0		65	190.05
190.06	19006	OTHER PROPERTY	0	0	0		27,676	190.06
191.00	19100	RESEARCH	0	0	0		0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
193.00	19300	NONPAID WORKERS	0	0	0		0	193.00
200.00		Cross Foot Adjustments				9,254	9,254	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	58,136	26,997	0	9,254	1,874,095	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	UTILITIES			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
13.01	01301	HOUSE SUPERVISORS			13.01
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	425,293	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	15,513	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	255,680	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,323	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	256,242	54.00
60.00	06000	LABORATORY	0	97,663	60.00
64.00	06400	INTRAVENOUS THERAPY	0	22,245	64.00
65.00	06500	RESPIRATORY THERAPY	0	29,952	65.00
66.00	06600	PHYSICAL THERAPY	0	146,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	32,609	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,618	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,478	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	88,171	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	3,454	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	145,697	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	90.02
91.00	09100	EMERGENCY	0	268,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,832,200	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	190.01
190.02	19002	OUTREACH	0	4,900	190.02
190.03	19003	FOUNDATION	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	65	190.05
190.06	19006	OTHER PROPERTY	0	27,676	190.06
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		Cross Foot Adjustments	0	9,254	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,874,095	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	57,586					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		54,306				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,027	1,027	7,571,149			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,528	3,528	540,811	-6,511,049	17,421,880	5.00
7.00	00700	OPERATION OF PLANT	4,436	4,436	414,165	0	1,269,422	7.00
7.01	00701	UTILITIES	0	0	0	0	359,967	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	0	0	72,546	8.00
9.00	00900	HOUSEKEEPING	948	948	192,149	0	325,150	9.00
10.00	01000	DIETARY	1,738	1,738	64,869	0	159,816	10.00
11.00	01100	CAFETERIA	1,005	1,005	124,019	0	154,627	11.00
13.00	01300	NURSING ADMINISTRATION	1,401	1,401	486,826	0	761,434	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	382,577	0	507,165	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,092	2,092	0	0	461,449	14.00
15.00	01500	PHARMACY	1,169	1,169	228,481	0	548,814	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	0	27,029	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	341,058	0	369,606	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,751	7,751	1,022,457	0	1,719,617	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	55,190	0	83,086	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	441,478	0	806,375	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	221	221	80,102	0	116,311	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,767	5,767	843,723	0	1,646,605	54.00
60.00	06000	LABORATORY	1,701	1,701	340	0	1,706,283	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	63,892	0	106,372	64.00
65.00	06500	RESPIRATORY THERAPY	284	284	329,533	0	474,506	65.00
66.00	06600	PHYSICAL THERAPY	4,063	4,063	359,627	0	743,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	919	919	81,904	0	137,571	67.00
68.00	06800	SPEECH PATHOLOGY	610	610	53,985	0	90,810	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	25,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	20,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,509,842	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	42,809	0	99,443	90.00
90.01	09001	VISITING SPECIALTY CLINIC	3,750	3,750	191,071	0	388,744	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,078	4,078	1,230,083	0	2,694,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,306	54,306	7,571,149	-6,511,049	17,386,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	448	0	0	0	4,471	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	3,594	190.05
190.06	19006	OTHER PROPERTY	2,832	0	0	0	26,840	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	545,157	1,123,585	1,902,976		6,511,049	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.466832	20.689887	0.251346		0.373728	203.00

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			30,971		313,958	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.004091		0.018021	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	39,923					7.00
7.01	00701	UTILITIES	0	48,147				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	11,186			8.00
9.00	00900	HOUSEKEEPING	948	948	0	41,254		9.00
10.00	01000	DIETARY	1,738	1,738	0	1,738	4,971	10.00
11.00	01100	CAFETERIA	1,005	1,005	0	1,005	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,401	1,401	0	1,401	0	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,092	2,092	0	0	0	14.00
15.00	01500	PHARMACY	1,169	1,169	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	753	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,751	7,751	2,984	7,751	4,971	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	0	250	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	810	6,027	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	221	221	177	221	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,767	5,767	1,987	5,767	0	54.00
60.00	06000	LABORATORY	1,701	1,701	0	1,701	0	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	0	450	0	64.00
65.00	06500	RESPIRATORY THERAPY	284	284	0	284	0	65.00
66.00	06600	PHYSICAL THERAPY	145	4,063	340	4,063	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	33	919	77	919	0	67.00
68.00	06800	SPEECH PATHOLOGY	22	610	51	610	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	0	38	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	3,750	3,750	141	3,750	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,078	4,078	4,619	4,078	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,923	45,315	11,186	40,806	4,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	448	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	2,832	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,743,841	494,497	115,843	497,813	334,282	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.680109	10.270567	10.356070	12.067024	67.246429	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	158,345	6,487	11,584	39,123	64,332	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	3.966260	0.134733	1.035580	0.948344	12.941460	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	HOUSE SUPERVISORS (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	13.00	13.01	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	213,556					11.00
13.00	01300	NURSING ADMINISTRATION	12,594	84,173				13.00
13.01	01301	HOUSE SUPERVISORS	9,818	0	84,173			13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	418,562		14.00
15.00	01500	PHARMACY	8,164	31	31	30,113	1,524,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,161	0	0	2,325	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,845	33,630	33,630	46,259	2,892	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,521	1,521	1,521	16,426	107	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,171	10,095	10,095	63,990	2,357	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,207	2,207	2,207	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,393	1,083	1,083	38,197	2,912	54.00
60.00	06000	LABORATORY	25,281	30	30	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,670	1,670	1,670	8,423	703	64.00
65.00	06500	RESPIRATORY THERAPY	10,853	0	0	39,583	0	65.00
66.00	06600	PHYSICAL THERAPY	11,158	0	0	6,269	27	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,545	0	0	1,418	6	67.00
68.00	06800	SPEECH PATHOLOGY	1,675	0	0	941	4	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,900	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,168	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,509,067	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	680	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	6,882	3,613	3,613	4,186	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	40,938	30,293	30,293	113,564	6,716	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,556	84,173	84,173	417,763	1,524,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	799	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	278,763	1,154,933	709,523	746,770	882,058	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.305339	13.720944	8.429342	1.784132	0.578478	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,675	67,320	12,483	79,983	58,136	204.00

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	HOUSE SUPERVISORS (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	13.00	13.01	14.00	15.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.181100	0.799781	0.148302	0.191090	0.038127	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	UTILITIES					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
13.01	01301	HOUSE SUPERVISORS					13.01
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,246,135				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,106,966	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	314,572	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,445,245	0	100		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,085,196	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,231,451	0	0		54.00
60.00	06000	LABORATORY	5,935,659	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	1,719,044	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,289,470	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,537,943	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	346,999	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	201,996	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	152,990	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	94,034	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,393,884	0	0		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	64,394	0	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	660,046	0	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	20,666,246	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,246,135	0	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0		190.01
190.02	19002	OUTREACH	0	0	0		190.02
190.03	19003	FOUNDATION	0	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0		190.05
190.06	19006	OTHER PROPERTY	0	0	0		190.06
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
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)	86,843	0	517,318		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001311	0.000000	5,173.180000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,997	0	9,254		204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 9:03 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000408	0.000000	92.540000		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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:03 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	4,123,090		4,123,090	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	196,099		196,099	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,393,498		2,393,498	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,393		229,393	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,806,292		2,806,292	0	0	54.00
60.00	06000	LABORATORY	2,497,712		2,497,712	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	232,694		232,694	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	757,069	0	757,069	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,149,950	0	1,149,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,062	0	218,062	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	143,995	0	143,995	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,990		81,990	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,812		63,812	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,958,078		2,958,078	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	140,089		140,089	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	880,400		880,400	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	4,976,838		4,976,838	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,850,735		1,850,735		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,699,796	0	25,699,796	0	0	200.00
201.00		Less Observation Beds	1,850,735		1,850,735		0	201.00
202.00		Total (see instructions)	23,849,061	0	23,849,061	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,713,078		1,713,078			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	314,572		314,572			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	963,037	4,482,208	5,445,245	0.439557	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	741,567	343,629	1,085,196	0.211384	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,313	12,054,138	12,231,451	0.229432	0.000000	54.00
60.00	06000	LABORATORY	434,609	5,501,050	5,935,659	0.420798	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,719,044	1,719,044	0.135362	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	180,249	1,109,221	1,289,470	0.587116	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	107,874	1,430,069	1,537,943	0.747720	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,542	323,457	346,999	0.628423	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,918	199,078	201,996	0.712861	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,771	136,219	152,990	0.535917	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	94,034	94,034	0.678606	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644,098	7,749,786	8,393,884	0.352409	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	64,394	64,394	2.175498	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	660,046	660,046	1.333846	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	180,699	20,485,547	20,666,246	0.240820	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,550	4,388,338	4,393,888	0.421207	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,505,877	60,740,258	66,246,135			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,505,877	60,740,258	66,246,135			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	90.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,123,090		4,123,090	0	4,123,090	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	196,099		196,099	0	196,099	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,393,498		2,393,498	0	2,393,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,393		229,393	0	229,393	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,806,292		2,806,292	0	2,806,292	54.00
60.00	06000	LABORATORY	2,497,712		2,497,712	0	2,497,712	60.00
64.00	06400	INTRAVENOUS THERAPY	232,694		232,694	0	232,694	64.00
65.00	06500	RESPIRATORY THERAPY	757,069	0	757,069	0	757,069	65.00
66.00	06600	PHYSICAL THERAPY	1,149,950	0	1,149,950	0	1,149,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,062	0	218,062	0	218,062	67.00
68.00	06800	SPEECH PATHOLOGY	143,995	0	143,995	0	143,995	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,990		81,990	0	81,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,812		63,812	0	63,812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,958,078		2,958,078	0	2,958,078	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	140,089		140,089	0	140,089	90.00
90.01	09001	VISITING SPECIALTY CLINIC	880,400		880,400	0	880,400	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	4,976,838		4,976,838	0	4,976,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,850,735		1,850,735		1,850,735	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,699,796	0	25,699,796	0	25,699,796	200.00
201.00		Less Observation Beds	1,850,735		1,850,735		1,850,735	201.00
202.00		Total (see instructions)	23,849,061	0	23,849,061	0	23,849,061	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,713,078		1,713,078			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	314,572		314,572			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	963,037	4,482,208	5,445,245	0.439557	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	741,567	343,629	1,085,196	0.211384	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,313	12,054,138	12,231,451	0.229432	0.000000	54.00
60.00	06000	LABORATORY	434,609	5,501,050	5,935,659	0.420798	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,719,044	1,719,044	0.135362	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	180,249	1,109,221	1,289,470	0.587116	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	107,874	1,430,069	1,537,943	0.747720	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,542	323,457	346,999	0.628423	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,918	199,078	201,996	0.712861	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,771	136,219	152,990	0.535917	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	94,034	94,034	0.678606	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644,098	7,749,786	8,393,884	0.352409	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	64,394	64,394	2.175498	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	660,046	660,046	1.333846	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	180,699	20,485,547	20,666,246	0.240820	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,550	4,388,338	4,393,888	0.421207	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,505,877	60,740,258	66,246,135			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,505,877	60,740,258	66,246,135			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.439557	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211384	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.229432	54.00
60.00	06000	LABORATORY	0.420798	60.00
64.00	06400	INTRAVENOUS THERAPY	0.135362	64.00
65.00	06500	RESPIRATORY THERAPY	0.587116	65.00
66.00	06600	PHYSICAL THERAPY	0.747720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628423	67.00
68.00	06800	SPEECH PATHOLOGY	0.712861	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.535917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352409	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	2.175498	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1.333846	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	90.02
91.00	09100	EMERGENCY	0.240820	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421207	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		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

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

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,393,498	255,680	2,137,818	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,393	13,323	216,070	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,806,292	256,242	2,550,050	0	0	54.00
60.00	06000	LABORATORY	2,497,712	97,663	2,400,049	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	232,694	22,245	210,449	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	757,069	29,952	727,117	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,149,950	146,573	1,003,377	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,062	32,609	185,453	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	143,995	21,618	122,377	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,990	5,478	76,512	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,812	4,255	59,557	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,958,078	88,171	2,869,907	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	140,089	3,454	136,635	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	880,400	145,697	734,703	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,976,838	268,434	4,708,404	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,850,735	190,901	1,659,834	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	21,380,607	1,582,295	19,798,312	0	0	200.00
201.00		Less Observation Beds	1,850,735	190,901	1,659,834	0	0	201.00
202.00		Total (line 200 minus line 201)	19,529,872	1,391,394	18,138,478	0	0	202.00

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

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,393,498	5,445,245	0.439557	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,393	1,085,196	0.211384	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,806,292	12,231,451	0.229432	54.00
60.00	06000	LABORATORY	2,497,712	5,935,659	0.420798	60.00
64.00	06400	INTRAVENOUS THERAPY	232,694	1,719,044	0.135362	64.00
65.00	06500	RESPIRATORY THERAPY	757,069	1,289,470	0.587116	65.00
66.00	06600	PHYSICAL THERAPY	1,149,950	1,537,943	0.747720	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,062	346,999	0.628423	67.00
68.00	06800	SPEECH PATHOLOGY	143,995	201,996	0.712861	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,990	152,990	0.535917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,812	94,034	0.678606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,958,078	8,393,884	0.352409	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
90.00	09000	CLINIC	140,089	64,394	2.175498	90.00
90.01	09001	VISITING SPECIALTY CLINIC	880,400	660,046	1.333846	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	90.02
91.00	09100	EMERGENCY	4,976,838	20,666,246	0.240820	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,850,735	4,393,888	0.421207	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	21,380,607	64,218,485		200.00
201.00		Less Observation Beds	1,850,735	0		201.00
202.00		Total (line 200 minus line 201)	19,529,872	64,218,485		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 9:03 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	255,680	5,445,245	0.046955	5,679	267	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,323	1,085,196	0.012277	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,242	12,231,451	0.020949	50,818	1,065	54.00
60.00	06000	LABORATORY	97,663	5,935,659	0.016454	69,597	1,145	60.00
64.00	06400	INTRAVENOUS THERAPY	22,245	1,719,044	0.012940	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,952	1,289,470	0.023228	72,102	1,675	65.00
66.00	06600	PHYSICAL THERAPY	146,573	1,537,943	0.095305	18,634	1,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,609	346,999	0.093974	1,841	173	67.00
68.00	06800	SPEECH PATHOLOGY	21,618	201,996	0.107022	2,067	221	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,478	152,990	0.035806	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,255	94,034	0.045250	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,171	8,393,884	0.010504	121,697	1,278	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	3,454	64,394	0.053639	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	145,697	660,046	0.220738	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	268,434	20,666,246	0.012989	5,221	68	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	190,901	4,393,888	0.043447	1,050	46	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,582,295	64,218,485		348,706	7,714	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306

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

Worksheet D Part IV

Date/Time Prepared: 6/29/2020 9:03 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	517,318	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	517,318	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 9:03 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	517,318	0	5,445,245	0.095004	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,085,196	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,231,451	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,935,659	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,719,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,289,470	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,537,943	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	346,999	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	201,996	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	152,990	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	94,034	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,393,884	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	64,394	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	660,046	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	20,666,246	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,393,888	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	517,318	0	64,218,485		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306

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

Worksheet D Part IV

Date/Time Prepared: 6/29/2020 9:03 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	5,679	540	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	50,818	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	69,597	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	72,102	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	18,634	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,841	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,067	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	121,697	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	5,221	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,050	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		348,706	540	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 9:03 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	0.439557	0	1,218,073	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211384	0	8,717	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.229432	0	3,636,189	0	0	54.00
60.00	06000	LABORATORY	0.420798	0	1,794,387	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.135362	0	544,216	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.587116	0	345,530	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.747720	0	486,221	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628423	0	52,718	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.712861	0	4,654	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.535917	0	31,954	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678606	0	6,646	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352409	0	3,730,940	968	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.175498	0	35,610	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1.333846	0	344,073	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.240820	0	5,528,190	335	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421207	0	1,933,617	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	19,701,735	1,303	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	19,701,735	1,303	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	535,413	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,843	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	834,258	0	54.00
60.00	06000	LABORATORY	755,074	0	60.00
64.00	06400	INTRAVENOUS THERAPY	73,666	0	64.00
65.00	06500	RESPIRATORY THERAPY	202,866	0	65.00
66.00	06600	PHYSICAL THERAPY	363,557	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,129	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,318	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,125	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,510	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,314,817	341	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	77,469	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	458,940	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	90.02
91.00	09100	EMERGENCY	1,331,299	81	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	814,453	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,821,737	422	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,821,737	422	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306

Component CCN: 15-Z306

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

Worksheet D Part IV

Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Swing Beds - SNF | 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	517,318	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	517,318	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV

Component CCN: 15-Z306 | Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Swing Beds - SNF | 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	517,318	0	5,445,245	0.095004	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,085,196	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,231,451	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,935,659	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,719,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,289,470	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,537,943	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	346,999	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	201,996	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	152,990	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	94,034	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,393,884	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	64,394	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	660,046	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	20,666,246	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,393,888	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	517,318	0	64,218,485		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Swing Beds - SNF | 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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,228	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	10,403	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	615	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	28,652	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,029	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	55,180	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		107,107	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 9:03 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	0.439557	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211384	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.229432	0	0	0	0	54.00
60.00	06000	LABORATORY	0.420798	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.135362	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.587116	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.747720	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628423	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.712861	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.535917	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678606	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352409	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.175498	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1.333846	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.240820	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421207	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V

Component CCN: 15-Z306 | Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	425,293	35,165	390,128	1,359	287.07	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	15,513		15,513	215	72.15	43.00
200.00	Total (lines 30 through 199)	440,806		405,641	1,574		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	20	5,741	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	29	2,092	43.00
200.00	Total (lines 30 through 199)	49	7,833	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	255,680	5,445,245	0.046955	67,564	3,172	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,323	1,085,196	0.012277	54,555	670	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,242	12,231,451	0.020949	3,763	79	54.00
60.00	06000	LABORATORY	97,663	5,935,659	0.016454	24,611	405	60.00
64.00	06400	INTRAVENOUS THERAPY	22,245	1,719,044	0.012940	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,952	1,289,470	0.023228	3,017	70	65.00
66.00	06600	PHYSICAL THERAPY	146,573	1,537,943	0.095305	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,609	346,999	0.093974	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,618	201,996	0.107022	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,478	152,990	0.035806	929	33	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,255	94,034	0.045250	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,171	8,393,884	0.010504	26,689	280	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	3,454	64,394	0.053639	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	145,697	660,046	0.220738	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	268,434	20,666,246	0.012989	5,322	69	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	190,901	4,393,888	0.043447	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,582,295	64,218,485		186,450	4,778	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,359	0.00	20	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	215	0.00	29	43.00
200.00		Total (lines 30 through 199)		0	1,574		49	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	517,318	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	517,318	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	517,318	0	5,445,245	0.095004	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,085,196	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,231,451	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,935,659	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,719,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,289,470	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,537,943	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	346,999	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	201,996	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	152,990	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	94,034	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,393,884	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	64,394	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	660,046	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	20,666,246	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,393,888	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	517,318	0	64,218,485		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	67,564	6,419	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	54,555	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,763	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	24,611	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,017	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	929	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	26,689	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	5,322	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		186,450	6,419	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:03 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)	1,627	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,359	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)	694	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	116	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	152	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)	223	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)	116	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)	4,123,090	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)	18,073	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)	340,908	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,782,182	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)	3,782,182	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)	2,783.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	620,622	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)	620,622	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	146,922	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	767,544	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)	322,835	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)	322,835	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)	665	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,783.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,850,735	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/29/2020 9:03 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	425,293	4,123,090	0.103149	1,850,735	190,901	90.00
91.00	Nursing School cost	0	4,123,090	0.000000	1,850,735	0	91.00
92.00	Allied health cost	0	4,123,090	0.000000	1,850,735	0	92.00
93.00	All other Medical Education	0	4,123,090	0.000000	1,850,735	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,627	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,359	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)	694	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	116	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	152	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)	20	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)	215	15.00
16.00	Nursery days (title V or XIX only)	29	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)	4,123,090	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)	18,073	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)	340,908	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,782,182	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)	3,782,182	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)	2,783.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	55,661	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)	55,661	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	196,099	215	912.09	29	26,451	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	65,405	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	147,517	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)	7,833	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,197	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	19,030	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	128,487	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)	665	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,783.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,850,735	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	425,293	4,123,090	0.103149	1,850,735	190,901	90.00
91.00	Nursing School cost	0	4,123,090	0.000000	1,850,735	0	91.00
92.00	Allied health cost	0	4,123,090	0.000000	1,850,735	0	92.00
93.00	All other Medical Education	0	4,123,090	0.000000	1,850,735	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 9:03 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		437,953		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.439557	5,679	2,496	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211384	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.229432	50,818	11,659	54.00
60.00	06000	LABORATORY	0.420798	69,597	29,286	60.00
64.00	06400	INTRAVENOUS THERAPY	0.135362	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.587116	72,102	42,332	65.00
66.00	06600	PHYSICAL THERAPY	0.747720	18,634	13,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628423	1,841	1,157	67.00
68.00	06800	SPEECH PATHOLOGY	0.712861	2,067	1,473	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.535917	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678606	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352409	121,697	42,887	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.175498	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1.333846	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.240820	5,221	1,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421207	1,050	442	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		348,706	146,922	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)		348,706		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1306 Component CCN: 15-Z306	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/29/2020 9:03 am
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.439557	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211384	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.229432	4,228	970	54.00
60.00	06000	LABORATORY	0.420798	10,403	4,378	60.00
64.00	06400	INTRAVENOUS THERAPY	0.135362	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.587116	615	361	65.00
66.00	06600	PHYSICAL THERAPY	0.747720	28,652	21,424	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628423	8,029	5,046	67.00
68.00	06800	SPEECH PATHOLOGY	0.712861	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.535917	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678606	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352409	55,180	19,446	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.175498	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1.333846	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.240820	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421207	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		107,107	51,625	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)		107,107		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 9:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		43,390		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		39,716		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.439557	67,564	29,698	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211384	54,555	11,532	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.229432	3,763	863	54.00
60.00	06000	LABORATORY	0.420798	24,611	10,356	60.00
64.00	06400	INTRAVENOUS THERAPY	0.135362	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.587116	3,017	1,771	65.00
66.00	06600	PHYSICAL THERAPY	0.747720	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628423	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.712861	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.535917	929	498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678606	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352409	26,689	9,405	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	2.175498	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1.333846	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.240820	5,322	1,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421207	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		186,450	65,405	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)		186,450		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part B | Date/Time Prepared: 6/29/2020 9:03 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,822,159	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)	6,822,159	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)	6,890,381	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)	74,790	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,604,762	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)	3,210,829	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)	3,210,829	30.00
31.00	Primary payer payments	7,783	31.00
32.00	Subtotal (line 30 minus line 31)	3,203,046	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,325,405	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	861,513	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,168,916	36.00
37.00	Subtotal (see instructions)	4,064,559	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)	4,064,559	40.00
40.01	Sequestration adjustment (see instructions)	81,291	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	4,109,729	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)	-126,461	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	246,518	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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 6/29/2020 9:03 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		726,079		4,109,729	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)		726,079		4,109,729	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		43,046		126,461	6.02
7.00	Total Medicare program liability (see instructions)		683,033		3,983,268	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: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/29/2020 9:03 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		388,486		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		388,486		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		23,695		0	6.02
7.00	Total Medicare program liability (see instructions)		364,791		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: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/29/2020 9:03 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: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 6/29/2020 9:03 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)	326,063	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)	52,141	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	116	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)	378,204	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	378,204	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)	378,204	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,968	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	372,236	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	372,236	0	19.00
19.01	Sequestration adjustment (see instructions)	7,445	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	388,486	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)	-23,695	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	13,532	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: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 9:03 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	767,544	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)	767,544	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	775,219	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)	775,219	19.00
20.00	Deductibles (exclude professional component)	91,388	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	683,831	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	683,831	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	20,217	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	13,141	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,749	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	696,972	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)	696,972	30.00
30.01	Sequestration adjustment (see instructions)	13,939	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	726,079	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)	-43,046	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	27,743	34.00

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

Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/29/2020 9:03 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	11,705,236	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	101,973	0	0	0	3.00
4.00	Accounts receivable	3,051,761	0	0	0	4.00
5.00	Other receivable	-1,202,319	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	435,686	0	0	0	7.00
8.00	Prepaid expenses	121,799	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)	14,214,136	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	148,000	0	0	0	12.00
13.00	Land improvements	438,464	0	0	0	13.00
14.00	Accumulated depreciation	-370,610	0	0	0	14.00
15.00	Buildings	6,153,159	0	0	0	15.00
16.00	Accumulated depreciation	-3,544,505	0	0	0	16.00
17.00	Leasehold improvements	791,602	0	0	0	17.00
18.00	Accumulated depreciation	-511,257	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	22,679	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	11,293,717	0	0	0	23.00
24.00	Accumulated depreciation	-6,830,122	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)	7,591,127	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,333,331	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,741,349	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,074,680	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,879,943	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	970,680	0	0	0	37.00
38.00	Salaries, wages, and fees payable	780,506	0	0	0	38.00
39.00	Payroll taxes payable	-603	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	3,788,930	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,539,513	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	38,181	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	38,181	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,577,694	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,302,249				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)	25,302,249	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,879,943	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1306

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

Worksheet G-1

Date/Time Prepared:
6/29/2020 9:03 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		28,201,859		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,014,696				2.00
3.00	Total (sum of line 1 and line 2)		29,216,555		0		3.00
4.00	DONATED PPE	27,858		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		27,858		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,244,413		0		11.00
12.00	INTERCOMPANY CAPITAL TRANSFER	3,942,162		0		0	12.00
13.00	ROUNDING	2		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,942,164		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,302,249		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	DONATED PPE		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	INTERCOMPANY CAPITAL TRANSFER		0		12.00
13.00	ROUNDING		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: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/29/2020 9:03 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,924,526		1,924,526	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	103,124		103,124	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)	2,027,650		2,027,650	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	2,027,650		2,027,650	17.00
18.00	Ancillary services	3,291,977	35,141,933	38,433,910	18.00
19.00	Outpatient services	186,249	25,598,325	25,784,574	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	80,344	80,344	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,505,876	60,820,602	66,326,478	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,428,873		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)		25,428,873		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 6/29/2020 9:03 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,326,478	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,526,886	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,799,592	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,428,873	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-629,281	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	1,643,977	24.00
25.00	Total other income (sum of lines 6-24)	1,643,977	25.00
26.00	Total (line 5 plus line 25)	1,014,696	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)	1,014,696	29.00