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: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 8:41 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/29/2020 Time: 8:41 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 TIPTON HOSPITAL (15-1311) 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) CARA BREIDSTER
Officer or Administrator of Provider(s)

CFO
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	367,544	425,293	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	61,695	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	429,239	425,293	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:41 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: TIPTON	State: IN	Zip Code: 46072	County: TIPTON	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 TIPTON HOSPITAL	151311	99915	1	11/12/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH TIPTON HOSPITAL	15Z311	29020		11/12/2005	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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:41 am

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

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:41 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:41 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:41 am

		1.00	2.00	3.00	
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.	N		108.00

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		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	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:	55,271	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:41 am

		1.00	2.00	
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

	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: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:41 am

		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	27	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/29/2020 8:41 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2020	Y	04/01/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:41 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:41 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:41 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	25	9,125	50,400.00	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)		25	9,125	50,400.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	50,400.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:41 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,217	13	2,100			1.00
2.00	HMO and other (see instructions)	423	82				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	180	0	180			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	10			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,397	13	2,290			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,397	13	2,290	0.00	172.75	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	172.75	27.00
28.00	Observation Bed Days		6	602			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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:41 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	344	4	595	1.00
2.00	HMO and other (see instructions)			106	22		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	344	4	595	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/29/2020 8:41 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)	0.336493	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	689,444	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	10,171,043	6.00
7.00	Medicaid cost (line 1 times line 6)	3,422,485	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)	2,733,041	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,733,041	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)	1,283,382	56,566	1,339,948	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	431,849	56,566	488,415	21.00
22.00	Payments received from patients for amounts previously written off as charity care	3,094	0	3,094	22.00
23.00	Cost of charity care (line 21 minus line 22)	428,755	56,566	485,321	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)	2,377,515	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	436,935	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	672,207	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,705,308	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	809,096	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,294,417	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,027,458	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:41 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	774,627	774,627	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES		0	0	702,804	702,804	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,198,787	1,198,787	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	70,986	38,817	109,803	1,852,521	1,962,324	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	797,328	9,799,577	10,596,905	-2,429,426	8,167,479	5.00
7.00	00700	OPERATION OF PLANT	904,318	3,328,831	4,233,149	-44,647	4,188,502	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	35,590	35,590	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	52,083	88,984	141,067	-24,944	116,123	8.00
9.00	00900	HOUSEKEEPING	313,132	176,003	489,135	-124,329	364,806	9.00
10.00	01000	DIETARY	460,173	519,282	979,455	-800,813	178,642	10.00
11.00	01100	CAFETERIA	0	0	0	693,861	693,861	11.00
13.00	01300	NURSING ADMINISTRATION	499,596	160,008	659,604	-28,475	631,129	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,511	18,511	770,490	789,001	14.00
15.00	01500	PHARMACY	646,617	4,315,550	4,962,167	-3,694,467	1,267,700	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,827,857	1,152,529	2,980,386	-472,881	2,507,505	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	894,294	2,685,623	3,579,917	-2,196,129	1,383,788	50.00
53.00	05300	ANESTHESIOLOGY	179,225	329,132	508,357	-15,620	492,737	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,092,126	611,389	1,703,515	-319,589	1,383,926	54.00
60.00	06000	LABORATORY	0	1,343,257	1,343,257	55	1,343,312	60.00
65.00	06500	RESPIRATORY THERAPY	507,211	185,018	692,229	-127,260	564,969	65.00
66.00	06600	PHYSICAL THERAPY	721,786	427,523	1,149,309	-383,168	766,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,101	44,348	220,449	14,148	234,597	67.00
68.00	06800	SPEECH PATHOLOGY	15,854	2,278	18,132	437	18,569	68.00
69.00	06900	ELECTROCARDIOLOGY	499,318	283,622	782,940	-88,322	694,618	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	366,200	366,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,164,957	1,164,957	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,714,917	3,714,917	73.00
73.01	03480	ONCOLOGY	196,558	80,856	277,414	-43,493	233,921	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	103,344	44,182	147,526	-16,895	130,631	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,101,951	1,933,990	3,035,941	-283,705	2,752,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,059,858	27,569,310	38,629,168	195,231	38,824,399	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	94,651	183,990	278,641	-169,494	109,147	192.00
192.01	19201	OCCUPATIONAL MEDICINE	35,669	65,947	101,616	-25,737	75,879	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	11,190,178	27,819,247	39,009,425	0	39,009,425	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:41 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	748,609	1,523,236		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	-157,066	545,738		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	313,056	1,511,843		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	573,331	2,535,655		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,081,038	7,086,441		5.00
7.00	00700	OPERATION OF PLANT	-37,653	4,150,849		7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	-11,939	23,651		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	116,123		8.00
9.00	00900	HOUSEKEEPING	-15,986	348,820		9.00
10.00	01000	DIETARY	0	178,642		10.00
11.00	01100	CAFETERIA	-219,040	474,821		11.00
13.00	01300	NURSING ADMINISTRATION	-660	630,469		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	789,001		14.00
15.00	01500	PHARMACY	-489,211	778,489		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-516,499	1,991,006		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-301,054	1,082,734		50.00
53.00	05300	ANESTHESIOLOGY	-433,392	59,345		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-110,737	1,273,189		54.00
60.00	06000	LABORATORY	0	1,343,312		60.00
65.00	06500	RESPIRATORY THERAPY	0	564,969		65.00
66.00	06600	PHYSICAL THERAPY	-18	766,123		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	234,597		67.00
68.00	06800	SPEECH PATHOLOGY	0	18,569		68.00
69.00	06900	ELECTROCARDIOLOGY	-158,471	536,147		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	366,200		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,164,957		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,714,917		73.00
73.01	03480	ONCOLOGY	0	233,921		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	130,631		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,071,194	1,681,042		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,968,962	35,855,437		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	109,147		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	75,879		192.01
192.02	19202	VACANT SPACE	0	0		192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,968,962	36,040,463		200.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:41 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	553,461	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,196,797	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	1,750,258	
	B - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	702,804	1.00
2.00		0.00	0	0	2.00
	0		0	702,804	
	C - OTHER CAPITAL				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,156	1.00
	0		0	17,156	
	D - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,852,473	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	1,852,473	
	E - CAFETERIA				
1.00	CAFETERIA	11.00	365,954	327,907	1.00
	0		365,954	327,907	
	F - MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	770,481	1.00
2.00	LABORATORY	60.00	0	55	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	366,200	3.00
4.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,164,957	4.00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48	5.00
6.00	NURSING ADMINISTRATION	13.00	0	94	6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,095	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
	0		0	2,302,930	
	G - DRUGS				
1.00	PHARMACY	15.00	0	64,234	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,714,917	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	9	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

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:41 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	0		0	3,779,160		
	H - ORTHOPEDIC CLERICAL STAFF					
1.00	OCCUPATIONAL THERAPY	67.00	45,020	0		1.00
2.00	SPEECH PATHOLOGY	68.00	1,026	0		2.00
	0		46,046	0		
	I - VP OF NURSING					
1.00	NURSING ADMINISTRATION	13.00	76,743	0		1.00
	0		76,743	0		
	J - MAINTENANCE & LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	190,042		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,820		2.00
3.00	OPERATION OF PLANT	7.00	0	8,152		3.00
4.00	OPERATION OF PLANT - OFFSITE	7.01	0	35,590		4.00
	0		0	235,604		
	L - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48,280		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,990		2.00
	TOTALS		0	50,270		
500.00	Grand Total: Increases		488,743	11,018,562		500.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:41 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,539,969	9		1.00
2.00	NURSING ADMINISTRATION	13.00	0	26,625	9		2.00
3.00	OPERATING ROOM	50.00	0	50,502	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41,624	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	8,305	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	49,870	0		6.00
7.00	EMERGENCY	91.00	0	937	0		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	32,426	0		8.00
	0		0	1,750,258			
	B - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	702,326	11		1.00
2.00	OPERATION OF PLANT	7.00	0	478	0		2.00
	0		0	702,804			
	C - OTHER CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	17,156	13		1.00
	0		0	17,156			
	D - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	78,674	0		1.00
2.00	OPERATION OF PLANT	7.00	0	47,885	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	24,944	0		3.00
4.00	HOUSEKEEPING	9.00	0	112,139	0		4.00
5.00	DIETARY	10.00	0	106,825	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	78,687	0		6.00
7.00	PHARMACY	15.00	0	94,182	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	355,917	0		8.00
9.00	OPERATING ROOM	50.00	0	165,134	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	7,556	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	192,158	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	91,341	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	142,918	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	30,499	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	589	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	58,071	0		16.00
17.00	ONCOLOGY	73.01	0	30,900	0		17.00
18.00	CARDIAC REHABILITATION	76.97	0	15,958	0		18.00
19.00	EMERGENCY	91.00	0	177,703	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	27,257	0		20.00
21.00	OCCUPATIONAL MEDICINE	192.01	0	13,136	0		21.00
	0		0	1,852,473			
	E - CAFETERIA						
1.00	DIETARY	10.00	365,954	327,907	0		1.00
	0		365,954	327,907			
	F - MEDICAL SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	420	0		1.00
2.00	OPERATION OF PLANT	7.00	0	4,436	0		2.00
3.00	HOUSEKEEPING	9.00	0	12,190	0		3.00
4.00	DIETARY	10.00	0	44	0		4.00
5.00	PHARMACY	15.00	0	31,428	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	105,353	0		6.00
7.00	OPERATING ROOM	50.00	0	1,964,657	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	1,418	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,495	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	27,284	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	19,340	0		11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	373	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	12,659	0		13.00
14.00	ONCOLOGY	73.01	0	9,290	0		14.00
15.00	CARDIAC REHABILITATION	76.97	0	937	0		15.00
16.00	EMERGENCY	91.00	0	81,482	0		16.00
17.00	OCCUPATIONAL MEDICINE	192.01	0	2,124	0		17.00
	0		0	2,302,930			
	G - DRUGS						
1.00	PHARMACY	15.00	0	3,633,091	0		1.00
2.00	DIETARY	10.00	0	83	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	11,611	0		3.00
4.00	OPERATING ROOM	50.00	0	15,836	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	6,646	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	56,312	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	330	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	296	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	17,592	0		9.00
10.00	ONCOLOGY	73.01	0	3,303	0		10.00
11.00	EMERGENCY	91.00	0	23,583	0		11.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:41 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
12.00	OCCUPATIONAL MEDICINE	192.01	0	10,477	0		12.00
	0		0	3,779,160			
	H - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSICAL THERAPY	66.00	46,046	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		46,046	0			
	I - VP OF NURSING						
1.00	ADMINISTRATIVE & GENERAL	5.00	76,743	0	0		1.00
	0		76,743	0			
	J - MAINTENANCE & LEASE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	124,698	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	110,906	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	235,604			
	L - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,270	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	50,270			
500.00	Grand Total: Decreases		488,743	11,018,562			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I Date/Time Prepared: 6/29/2020 8:41 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,872,457	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,559,570	903,511	0	903,511	213,241	6.00
7.00	HIT designated Assets	964,363	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,396,390	903,511	0	903,511	213,241	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,396,390	903,511	0	903,511	213,241	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	2,872,457	372,370	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,249,840	6,072,256	6.00
7.00	HIT designated Assets	964,363	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,086,660	6,444,626	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,086,660	6,444,626	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 6/29/2020 8:41 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
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0	0	1.01
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
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0		1.01
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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III | Date/Time Prepared: 6/29/2020 8:41 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	3,836,820	0	3,836,820	0.238509	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	12,249,840	0	12,249,840	0.761491	0	2.00
3.00	Total (sum of lines 1-2)	16,086,660	0	16,086,660	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,332,646	159,466	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	733,394	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,509,853	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,575,893	159,466	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	48,280	-17,156	0	1,523,236	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	-187,656	0	0	0	545,738	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,990	0	0	1,511,843	2.00
3.00	Total (sum of lines 1-2)	-187,656	50,270	-17,156	0	3,580,817	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:41 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	B	-890,460	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	11	1.01
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	-2,405,913			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	3,654,786			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-219,040	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-489,175	PHARMACY	15.00	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	A	784,011	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - INTERES		0	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	75,455	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:41 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	
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	-19,225	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-48,841	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	INVESTMENT FEES	A	7,008	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-15,986	HOUSEKEEPING	9.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-660	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-19,542	ELECTROCARDIOLOGY	69.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-36	PHARMACY	15.00	0	33.05
33.06	MEDICAID HOSPITAL ASSESSMENT FEE	B	-1,077,349	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	ASSISTED LIVING DEPRECIATION - BLDG	A	-125,780	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	ASSISTED LIVING DEPRECIATION - MVBLE	A	-397	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	CRNA SALARY EXPENSE	A	-179,225	ANESTHESIOLOGY	53.00	0	33.09
33.10	CRNA BENEFITS EXPENSE	A	-41,820	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	PATIENT PHONES - SALARY	A	-2,712	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PATIENT PHONES - BENEFITS	A	-633	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	EMPLOYEE BENEFITS	A	-1,852,477	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	CABLE	A	-2,541	OPERATION OF PLANT	7.00	0	33.14
33.15	LEASE REVENUE	B	-30,576	CAP REL COSTS-BLDG & FIXT	1.00	10	33.15
33.16	ACCRUED PTO	A	-70,986	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	LEASE DEPRECIATION - CARRY FORWARD A	A	284	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	EQUIPMENT DEPRECIATION - CARRY FORWA	A	31,899	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.18
33.19	TELEPHONE EQUIPMENT	A	-235	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	MARKETING	A	-28,979	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	MARKETING	A	-18	PHYSICAL THERAPY	66.00	0	33.21
33.22	MARKETING	A	201	EMERGENCY	91.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,968,962				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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:41 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	150,803	30,133	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	1,435,720	702,326	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	225,324	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	2,539,247	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5,616,577	5,533,375	4.01
4.02	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	0	35,112	4.02
4.03	7.01	OPERATION OF PLANT - OFFSITE	HOME OFFICE ALLOCATION	0	11,939	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY EXPENSE	510,237	510,237	4.04
4.05	7.00	OPERATION OF PLANT	RELATED PARTY EXPENSE	682,774	682,774	4.05
4.06	13.00	NURSING ADMINISTRATION	RELATED PARTY EXPENSE	36,576	36,576	4.06
4.07	30.00	ADULTS & PEDIATRICS	RELATED PARTY EXPENSE	457,878	457,878	4.07
4.08	50.00	OPERATING ROOM	RELATED PARTY EXPENSE	56,515	56,515	4.08
4.09	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY EXPENSE	126,652	126,652	4.09
4.10	60.00	LABORATORY	RELATED PARTY EXPENSE	1,310,139	1,310,139	4.10
4.11	69.00	ELECTROCARDIOLOGY	RELATED PARTY EXPENSE	335,708	335,708	4.11
4.12	73.01	ONCOLOGY	RELATED PARTY EXPENSE	10,810	10,810	4.12
4.13	91.00	EMERGENCY	RELATED PARTY EXPENSE	1,611,548	1,611,548	4.13
4.14	192.01	OCCUPATIONAL MEDICINE	RELATED PARTY EXPENSE	31,751	31,751	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,138,259	11,483,473	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:41 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	120,670	9		1.00
2.00	733,394	9		2.00
3.00	225,324	9		3.00
4.00	2,539,247	0		4.00
4.01	83,202	0		4.01
4.02	-35,112	0		4.02
4.03	-11,939	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
5.00	3,654,786			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	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/29/2020 8:41 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	13,367	13,367	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	516,264	516,264	0	0	0	2.00
3.00	50.00	OPERATING ROOM	301,054	301,054	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	254,167	254,167	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	110,737	110,737	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	138,929	138,929	0	0	0	6.00
7.00	91.00	EMERGENCY	1,559,527	1,071,395	488,132	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			2,894,045	2,405,913	488,132		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	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	13,367		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	516,264		2.00
3.00	50.00	OPERATING ROOM	0	0	0	301,054		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	254,167		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	110,737		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	138,929		6.00
7.00	91.00	EMERGENCY	0	0	0	1,071,395		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	2,405,913		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/29/2020 8:41 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					11	1.00
2.00	Line 1 multiplied by 15 hours per week					165	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					11	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	64.25	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	0.00	62.18	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	31.09			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					3,995	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					3,995	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					3,995	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					62.18	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					10,260	22.00
23.00	Total salary equivalency (see instructions)					10,260	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					60	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					60	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					60	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/29/2020 8:41 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	0.00	62.18	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	10,260		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	60		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	10,320		63.00
64.00	Total cost of outside supplier services (from your records)	2,181		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	60		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	60		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	60		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	60		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,523,236	1,523,236				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	545,738	0	545,738			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,511,843			1,511,843		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,535,655	6,756	2,731	6,724	2,551,866	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,086,441	105,493	42,637	104,992	168,084	5.00
7.00	00700	OPERATION OF PLANT	4,150,849	373,741	132,785	371,973	210,942	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	23,651	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	116,123	25,247	10,204	25,127	12,149	8.00
9.00	00900	HOUSEKEEPING	348,820	15,055	6,085	14,983	73,041	9.00
10.00	01000	DIETARY	178,642	13,348	5,395	13,285	21,978	10.00
11.00	01100	CAFETERIA	474,821	51,835	20,950	51,589	85,363	11.00
13.00	01300	NURSING ADMINISTRATION	630,469	34,403	13,905	34,240	134,437	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	789,001	32,564	13,161	32,410	0	14.00
15.00	01500	PHARMACY	778,489	11,735	4,743	11,680	150,831	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,991,006	151,327	61,162	150,610	426,368	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,082,734	190,780	77,107	189,875	208,604	50.00
53.00	05300	ANESTHESIOLOGY	59,345	3,600	1,455	3,583	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,273,189	98,378	39,761	97,912	254,750	54.00
60.00	06000	LABORATORY	1,343,312	38,463	15,546	38,281	0	60.00
65.00	06500	RESPIRATORY THERAPY	564,969	2,322	939	2,311	118,313	65.00
66.00	06600	PHYSICAL THERAPY	766,123	48,632	5,206	48,401	157,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,597	15,250	1,631	15,177	51,579	67.00
68.00	06800	SPEECH PATHOLOGY	18,569	351	38	349	3,937	68.00
69.00	06900	ELECTROCARDIOLOGY	536,147	25,832	10,440	25,709	116,471	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	366,200	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,164,957	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,714,917	0	0	0	0	73.00
73.01	03480	ONCOLOGY	233,921	15,413	6,230	15,340	45,849	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	130,631	18,148	7,335	18,062	24,106	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,681,042	108,906	44,016	108,389	257,042	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,855,437	1,387,579	523,462	1,381,002	2,521,468	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,147	111,867	12,661	111,336	22,078	192.00
192.01	19201	OCCUPATIONAL MEDICINE	75,879	19,598	7,921	19,505	8,320	192.01
192.02	19202	VACANT SPACE	0	4,192	1,694	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,040,463	1,523,236	545,738	1,511,843	2,551,866	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,507,647	7,507,647				5.00
7.00	00700	OPERATION OF PLANT	5,240,290	1,378,848	6,619,138			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	23,651	6,223	0	29,874		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	188,850	49,691	174,293	0	412,834	8.00
9.00	00900	HOUSEKEEPING	457,984	120,506	103,930	0	0	9.00
10.00	01000	DIETARY	232,648	61,215	92,149	0	0	10.00
11.00	01100	CAFETERIA	684,558	180,123	357,838	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	847,454	222,985	237,501	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	867,136	228,163	224,805	0	0	14.00
15.00	01500	PHARMACY	957,478	251,934	81,014	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,780,473	731,606	1,044,680	0	412,834	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,749,100	460,228	1,317,037	0	0	50.00
53.00	05300	ANESTHESIOLOGY	67,983	17,888	24,853	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,763,990	464,146	679,149	0	0	54.00
60.00	06000	LABORATORY	1,435,602	377,740	265,527	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	688,854	181,253	16,031	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,025,986	269,961	88,922	13,618	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	318,234	83,735	27,865	4,271	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,244	6,116	646	98	0	68.00
69.00	06900	ELECTROCARDIOLOGY	714,599	188,027	178,327	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	366,200	96,356	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,164,957	306,527	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,714,917	977,480	0	0	0	73.00
73.01	03480	ONCOLOGY	316,753	83,345	106,405	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	198,282	52,173	125,286	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,199,395	578,711	751,825	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,536,265	7,374,980	5,898,083	17,987	412,834	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	367,089	96,590	556,822	11,887	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	131,223	34,528	135,292	0	0	192.01
192.02	19202	VACANT SPACE	5,886	1,549	28,941	0	0	192.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,040,463	7,507,647	6,619,138	29,874	412,834	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	682,420					9.00
10.00	01000	DIETARY	9,176	395,188				10.00
11.00	01100	CAFETERIA	35,631	0	1,258,150			11.00
13.00	01300	NURSING ADMINISTRATION	23,649	0	65,928	1,397,517		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,385	0	0	0	1,342,489	14.00
15.00	01500	PHARMACY	8,067	0	73,981	0	18,148	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	104,023	395,188	299,860	793,674	53,955	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	131,140	0	124,363	221,434	302,593	50.00
53.00	05300	ANESTHESIOLOGY	2,475	0	9,365	0	797	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,625	0	145,621	0	15,055	54.00
60.00	06000	LABORATORY	26,440	0	85,874	0	18,439	60.00
65.00	06500	RESPIRATORY THERAPY	1,596	0	62,650	0	15,448	65.00
66.00	06600	PHYSICAL THERAPY	33,430	0	89,620	0	7,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,483	0	30,904	0	208	67.00
68.00	06800	SPEECH PATHOLOGY	241	0	1,873	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,757	0	53,192	37,373	7,161	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	203,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	648,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	10,595	0	25,847	32,446	5,532	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	12,475	0	13,953	41,125	617	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	74,862	0	150,397	271,465	43,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	592,050	395,188	1,233,428	1,397,517	1,341,258	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,898	0	15,826	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	13,472	0	8,896	0	1,231	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	682,420	395,188	1,258,150	1,397,517	1,342,489	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,390,622					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,272	6,620,565	0	6,620,565		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,146	4,311,041	0	4,311,041		50.00
53.00	05300	ANESTHESIOLOGY	0	123,361	0	123,361		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,328	3,136,914	0	3,136,914		54.00
60.00	06000	LABORATORY	0	2,209,622	0	2,209,622		60.00
65.00	06500	RESPIRATORY THERAPY	121	965,953	0	965,953		65.00
66.00	06600	PHYSICAL THERAPY	87	1,529,038	0	1,529,038		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	475,700	0	475,700		67.00
68.00	06800	SPEECH PATHOLOGY	0	32,218	0	32,218		68.00
69.00	06900	ELECTROCARDIOLOGY	274	1,196,710	0	1,196,710		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	666,469	0	666,469		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,120,170	0	2,120,170		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,366,978	6,059,375	0	6,059,375		73.00
73.01	03480	ONCOLOGY	1,203	582,126	0	582,126		73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	443,911	0	443,911		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,678	4,078,625	0	4,078,625		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,388,087	34,551,798	0	34,551,798		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,125,112	0	1,125,112		192.00
192.01	19201	OCCUPATIONAL MEDICINE	2,535	327,177	0	327,177		192.01
192.02	19202	VACANT SPACE	0	36,376	0	36,376		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,390,622	36,040,463	0	36,040,463		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,756	2,731	6,724	16,211	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	105,493	42,637	104,992	253,122	5.00
7.00	00700	OPERATION OF PLANT	0	373,741	132,785	371,973	878,499	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,247	10,204	25,127	60,578	8.00
9.00	00900	HOUSEKEEPING	0	15,055	6,085	14,983	36,123	9.00
10.00	01000	DIETARY	0	13,348	5,395	13,285	32,028	10.00
11.00	01100	CAFETERIA	0	51,835	20,950	51,589	124,374	11.00
13.00	01300	NURSING ADMINISTRATION	0	34,403	13,905	34,240	82,548	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,564	13,161	32,410	78,135	14.00
15.00	01500	PHARMACY	0	11,735	4,743	11,680	28,158	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	151,327	61,162	150,610	363,099	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	190,780	77,107	189,875	457,762	50.00
53.00	05300	ANESTHESIOLOGY	0	3,600	1,455	3,583	8,638	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,378	39,761	97,912	236,051	54.00
60.00	06000	LABORATORY	0	38,463	15,546	38,281	92,290	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,322	939	2,311	5,572	65.00
66.00	06600	PHYSICAL THERAPY	0	48,632	5,206	48,401	102,239	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,250	1,631	15,177	32,058	67.00
68.00	06800	SPEECH PATHOLOGY	0	351	38	349	738	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,832	10,440	25,709	61,981	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	15,413	6,230	15,340	36,983	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	18,148	7,335	18,062	43,545	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	108,906	44,016	108,389	261,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,387,579	523,462	1,381,002	3,292,043	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	111,867	12,661	111,336	235,864	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	19,598	7,921	19,505	47,024	192.01
192.02	19202	VACANT SPACE	0	4,192	1,694	0	5,886	192.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,523,236	545,738	1,511,843	3,580,817	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4.00	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,211					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,068	254,190				5.00
7.00	00700	OPERATION OF PLANT	1,340	46,679	926,518			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	211	0	211		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	77	1,682	24,397	0	86,734	8.00
9.00	00900	HOUSEKEEPING	464	4,080	14,548	0	0	9.00
10.00	01000	DIETARY	140	2,073	12,899	0	0	10.00
11.00	01100	CAFETERIA	542	6,099	50,089	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	854	7,550	33,244	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,725	31,467	0	0	14.00
15.00	01500	PHARMACY	958	8,530	11,340	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,708	24,771	146,230	0	86,734	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,325	15,583	184,354	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	606	3,479	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,619	15,715	95,064	0	0	54.00
60.00	06000	LABORATORY	0	12,790	37,167	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	752	6,137	2,244	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,001	9,141	12,447	96	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	328	2,835	3,900	30	0	67.00
68.00	06800	SPEECH PATHOLOGY	25	207	90	1	0	68.00
69.00	06900	ELECTROCARDIOLOGY	740	6,366	24,961	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,262	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,379	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,096	0	0	0	73.00
73.01	03480	ONCOLOGY	291	2,822	14,894	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	153	1,766	17,537	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,633	19,594	105,237	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,018	249,699	825,588	127	86,734	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	140	3,270	77,941	84	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	53	1,169	18,938	0	0	192.01
192.02	19202	VACANT SPACE	0	52	4,051	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,211	254,190	926,518	211	86,734	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	55,215					9.00
10.00	01000	DIETARY	742	47,882				10.00
11.00	01100	CAFETERIA	2,883	0	183,987			11.00
13.00	01300	NURSING ADMINISTRATION	1,913	0	9,641	135,750		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,811	0	0	0	119,138	14.00
15.00	01500	PHARMACY	653	0	10,819	0	1,611	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,417	47,882	43,850	77,095	4,788	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,611	0	18,186	21,509	26,853	50.00
53.00	05300	ANESTHESIOLOGY	200	0	1,369	0	71	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,472	0	21,295	0	1,336	54.00
60.00	06000	LABORATORY	2,139	0	12,558	0	1,636	60.00
65.00	06500	RESPIRATORY THERAPY	129	0	9,162	0	1,371	65.00
66.00	06600	PHYSICAL THERAPY	2,705	0	13,106	0	658	66.00
67.00	06700	OCCUPATIONAL THERAPY	848	0	4,519	0	18	67.00
68.00	06800	SPEECH PATHOLOGY	20	0	274	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,437	0	7,779	3,630	635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	18,096	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	57,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	857	0	3,780	3,152	491	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,009	0	2,040	3,995	55	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,057	0	21,994	26,369	3,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,903	47,882	180,372	135,750	119,029	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,222	0	2,314	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,090	0	1,301	0	109	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	55,215	47,882	183,987	135,750	119,138	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	62,069					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	191	805,765	0	805,765		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230	736,413	0	736,413		50.00
53.00	05300	ANESTHESIOLOGY	0	14,363	0	14,363		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59	376,611	0	376,611		54.00
60.00	06000	LABORATORY	0	158,580	0	158,580		60.00
65.00	06500	RESPIRATORY THERAPY	5	25,372	0	25,372		65.00
66.00	06600	PHYSICAL THERAPY	4	141,397	0	141,397		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,536	0	44,536		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,355	0	1,355		68.00
69.00	06900	ELECTROCARDIOLOGY	12	107,541	0	107,541		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,358	0	21,358		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,947	0	67,947		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,014	94,110	0	94,110		73.00
73.01	03480	ONCOLOGY	54	63,324	0	63,324		73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	70,100	0	70,100		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	387	446,424	0	446,424		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,956	3,175,196	0	3,175,196		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	325,835	0	325,835		192.00
192.01	19201	OCCUPATIONAL MEDICINE	113	69,797	0	69,797		192.01
192.02	19202	VACANT SPACE	0	9,989	0	9,989		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	62,069	3,580,817	0	3,580,817		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - INTERES (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	195,479					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	0	173,282				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			194,941			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	867	867	867	10,939,967		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,538	13,538	13,538	720,585	-7,507,647	5.00
7.00	00700	OPERATION OF PLANT	47,963	42,162	47,963	904,318	0	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,240	3,240	3,240	52,083	0	8.00
9.00	00900	HOUSEKEEPING	1,932	1,932	1,932	313,132	0	9.00
10.00	01000	DIETARY	1,713	1,713	1,713	94,219	0	10.00
11.00	01100	CAFETERIA	6,652	6,652	6,652	365,954	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,415	4,415	4,415	576,339	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,179	4,179	4,179	0	0	14.00
15.00	01500	PHARMACY	1,506	1,506	1,506	646,617	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,420	19,420	19,420	1,827,857	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,483	24,483	24,483	894,294	0	50.00
53.00	05300	ANESTHESIOLOGY	462	462	462	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,625	12,625	12,625	1,092,126	0	54.00
60.00	06000	LABORATORY	4,936	4,936	4,936	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	298	298	298	507,211	0	65.00
66.00	06600	PHYSICAL THERAPY	6,241	1,653	6,241	675,740	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,957	518	1,957	221,121	0	67.00
68.00	06800	SPEECH PATHOLOGY	45	12	45	16,880	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,315	3,315	3,315	499,318	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	1,978	1,978	1,978	196,558	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,329	2,329	2,329	103,344	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,976	13,976	13,976	1,101,951	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	178,070	166,209	178,070	10,809,647	-7,507,647	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,356	4,020	14,356	94,651	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	2,515	2,515	2,515	35,669	0	192.01
192.02	19202	VACANT SPACE	538	538	0	0	0	192.02
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)	1,523,236	545,738	1,511,843	2,551,866		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.792326	3.149421	7.755388	0.233261		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				16,211		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001482		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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,532,816					5.00
7.00	00700	OPERATION OF PLANT	5,240,290	123,046				7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	23,651	0	10,065			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	188,850	3,240	0	2,100		8.00
9.00	00900	HOUSEKEEPING	457,984	1,932	0	0	127,401	9.00
10.00	01000	DIETARY	232,648	1,713	0	0	1,713	10.00
11.00	01100	CAFETERIA	684,558	6,652	0	0	6,652	11.00
13.00	01300	NURSING ADMINISTRATION	847,454	4,415	0	0	4,415	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	867,136	4,179	0	0	4,179	14.00
15.00	01500	PHARMACY	957,478	1,506	0	0	1,506	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,780,473	19,420	0	2,100	19,420	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,749,100	24,483	0	0	24,483	50.00
53.00	05300	ANESTHESIOLOGY	67,983	462	0	0	462	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,763,990	12,625	0	0	12,625	54.00
60.00	06000	LABORATORY	1,435,602	4,936	0	0	4,936	60.00
65.00	06500	RESPIRATORY THERAPY	688,854	298	0	0	298	65.00
66.00	06600	PHYSICAL THERAPY	1,025,986	1,653	4,588	0	6,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	318,234	518	1,439	0	1,957	67.00
68.00	06800	SPEECH PATHOLOGY	23,244	12	33	0	45	68.00
69.00	06900	ELECTROCARDIOLOGY	714,599	3,315	0	0	3,315	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	366,200	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,164,957	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,714,917	0	0	0	0	73.00
73.01	03480	ONCOLOGY	316,753	1,978	0	0	1,978	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	198,282	2,329	0	0	2,329	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,199,395	13,976	0	0	13,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,028,618	109,642	6,060	2,100	110,530	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	367,089	10,351	4,005	0	14,356	192.00
192.01	19201	OCCUPATIONAL MEDICINE	131,223	2,515	0	0	2,515	192.01
192.02	19202	VACANT SPACE	5,886	538	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,507,647	6,619,138	29,874	412,834	682,420	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.263123	53.794012	2.968107	196.587619	5.356473	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	254,190	926,518	211	86,734	55,215	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008909	7.529851	0.020964	41.301905	0.433395	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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:41 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	6,870					10.00
11.00	01100	CAFETERIA	0	13,435				11.00
13.00	01300	NURSING ADMINISTRATION	0	704	104,665			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,410,934		14.00
15.00	01500	PHARMACY	0	790	0	32,592	3,779,171	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,870	3,202	59,441	96,896	11,611	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,328	16,584	543,416	13,986	50.00
53.00	05300	ANESTHESIOLOGY	0	100	0	1,432	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,555	0	27,037	3,608	54.00
60.00	06000	LABORATORY	0	917	0	33,114	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	669	0	27,742	330	65.00
66.00	06600	PHYSICAL THERAPY	0	957	0	13,314	236	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	330	0	373	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	20	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	568	2,799	12,860	744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	366,200	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,164,957	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,714,917	73.00
73.01	03480	ONCOLOGY	0	276	2,430	9,935	3,268	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	149	3,080	1,108	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,606	20,331	77,747	23,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,870	13,171	104,665	2,408,723	3,772,283	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	169	0	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	95	0	2,211	6,888	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	395,188	1,258,150	1,397,517	1,342,489	1,390,622	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	57.523726	93.647190	13.352286	0.556834	0.367970	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,882	183,987	135,750	119,138	62,069	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.969723	13.694604	1.296995	0.049416	0.016424	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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,620,565		6,620,565	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,311,041		4,311,041	0	0	50.00
53.00	05300	ANESTHESIOLOGY	123,361		123,361	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,136,914		3,136,914	0	0	54.00
60.00	06000	LABORATORY	2,209,622		2,209,622	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	965,953	0	965,953	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,529,038	0	1,529,038	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	475,700	0	475,700	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	32,218	0	32,218	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,196,710		1,196,710	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	666,469		666,469	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,120,170		2,120,170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,059,375		6,059,375	0	0	73.00
73.01	03480	ONCOLOGY	582,126		582,126	0	0	73.01
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	443,911		443,911	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,078,625		4,078,625	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,382,674		1,382,674		0	92.00
200.00		Subtotal (see instructions)	35,934,472	0	35,934,472	0	0	200.00
201.00		Less Observation Beds	1,382,674		1,382,674		0	201.00
202.00		Total (see instructions)	34,551,798	0	34,551,798	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:41 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	4,463,569		4,463,569			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,663,727	16,127,154	21,790,881	0.197837	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	275,320	661,152	936,472	0.131730	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	305,323	8,987,419	9,292,742	0.337566	0.000000	54.00
60.00	06000	LABORATORY	658,450	4,291,658	4,950,108	0.446379	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	361,718	828,767	1,190,485	0.811395	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	583,981	1,813,916	2,397,897	0.637658	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	268,076	549,688	817,764	0.581708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,097	34,779	58,876	0.547218	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	216,254	4,606,425	4,822,679	0.248142	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,252,930	2,476,705	3,729,635	0.178696	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,267,925	6,086,119	13,354,044	0.158766	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,777,845	14,555,727	16,333,572	0.370977	0.000000	73.00
73.01	03480	ONCOLOGY	2,748	1,787,309	1,790,057	0.325200	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	696,450	696,450	0.637391	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	440,303	12,644,561	13,084,864	0.311706	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	15,527	2,956,544	2,972,071	0.465222	0.000000	92.00
200.00		Subtotal (see instructions)	23,577,793	79,104,373	102,682,166			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,577,793	79,104,373	102,682,166			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,620,565		6,620,565	0	6,620,565	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,311,041		4,311,041	0	4,311,041	50.00
53.00	05300	ANESTHESIOLOGY	123,361		123,361	0	123,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,136,914		3,136,914	0	3,136,914	54.00
60.00	06000	LABORATORY	2,209,622		2,209,622	0	2,209,622	60.00
65.00	06500	RESPIRATORY THERAPY	965,953	0	965,953	0	965,953	65.00
66.00	06600	PHYSICAL THERAPY	1,529,038	0	1,529,038	0	1,529,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	475,700	0	475,700	0	475,700	67.00
68.00	06800	SPEECH PATHOLOGY	32,218	0	32,218	0	32,218	68.00
69.00	06900	ELECTROCARDIOLOGY	1,196,710		1,196,710	0	1,196,710	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	666,469		666,469	0	666,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,120,170		2,120,170	0	2,120,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,059,375		6,059,375	0	6,059,375	73.00
73.01	03480	ONCOLOGY	582,126		582,126	0	582,126	73.01
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	443,911		443,911	0	443,911	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,078,625		4,078,625	0	4,078,625	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,382,674		1,382,674		1,382,674	92.00
200.00		Subtotal (see instructions)	35,934,472	0	35,934,472	0	35,934,472	200.00
201.00		Less Observation Beds	1,382,674		1,382,674		1,382,674	201.00
202.00		Total (see instructions)	34,551,798	0	34,551,798	0	34,551,798	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,463,569		4,463,569			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,663,727	16,127,154	21,790,881	0.197837	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	275,320	661,152	936,472	0.131730	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	305,323	8,987,419	9,292,742	0.337566	0.000000	54.00
60.00	06000	LABORATORY	658,450	4,291,658	4,950,108	0.446379	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	361,718	828,767	1,190,485	0.811395	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	583,981	1,813,916	2,397,897	0.637658	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	268,076	549,688	817,764	0.581708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,097	34,779	58,876	0.547218	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	216,254	4,606,425	4,822,679	0.248142	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,252,930	2,476,705	3,729,635	0.178696	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,267,925	6,086,119	13,354,044	0.158766	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,777,845	14,555,727	16,333,572	0.370977	0.000000	73.00
73.01	03480	ONCOLOGY	2,748	1,787,309	1,790,057	0.325200	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	696,450	696,450	0.637391	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	440,303	12,644,561	13,084,864	0.311706	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	15,527	2,956,544	2,972,071	0.465222	0.000000	92.00
200.00		Subtotal (see instructions)	23,577,793	79,104,373	102,682,166			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,577,793	79,104,373	102,682,166			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 8:41 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	736,413	21,790,881	0.033795	2,726,476	92,141	50.00
53.00	05300	ANESTHESIOLOGY	14,363	936,472	0.015337	127,434	1,954	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	376,611	9,292,742	0.040527	101,499	4,113	54.00
60.00	06000	LABORATORY	158,580	4,950,108	0.032036	346,455	11,099	60.00
65.00	06500	RESPIRATORY THERAPY	25,372	1,190,485	0.021312	178,946	3,814	65.00
66.00	06600	PHYSICAL THERAPY	141,397	2,397,897	0.058967	293,243	17,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,536	817,764	0.054461	135,691	7,390	67.00
68.00	06800	SPEECH PATHOLOGY	1,355	58,876	0.023014	13,352	307	68.00
69.00	06900	ELECTROCARDIOLOGY	107,541	4,822,679	0.022299	127,640	2,846	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,358	3,729,635	0.005727	587,060	3,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,947	13,354,044	0.005088	4,057,619	20,645	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,110	16,333,572	0.005762	930,893	5,364	73.00
73.01	03480	ONCOLOGY	63,324	1,790,057	0.035375	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	70,100	696,450	0.100653	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	446,424	13,084,864	0.034118	11,802	403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	168,280	2,972,071	0.056620	0	0	92.00
200.00		Total (lines 50 through 199)	2,537,711	98,218,597		9,638,110	170,730	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	21,790,881	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	936,472	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,292,742	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,950,108	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,190,485	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,397,897	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	817,764	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	58,876	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,822,679	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,729,635	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,354,044	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,333,572	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	1,790,057	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	696,450	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	13,084,864	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,972,071	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	98,218,597		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:41 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	2,726,476	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	127,434	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	101,499	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	346,455	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	178,946	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	293,243	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	135,691	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	13,352	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	127,640	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	587,060	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,057,619	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	930,893	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	11,802	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		9,638,110	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:41 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	0.197837	0	3,829,300	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.131730	0	124,910	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337566	0	2,722,359	0	0	54.00
60.00	06000	LABORATORY	0.446379	0	1,434,227	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.811395	0	366,049	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.637658	0	649,764	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.581708	0	160,504	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.547218	0	18,300	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.248142	0	1,729,437	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178696	0	514,310	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.158766	0	1,237,609	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370977	0	7,368,035	4,574	0	73.00
73.01	03480	ONCOLOGY	0.325200	0	1,002,321	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.637391	0	295,558	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.311706	0	3,852,008	709	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465222	0	1,102,483	70	0	92.00
200.00		Subtotal (see instructions)		0	26,407,174	5,353	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	26,407,174	5,353	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	757,577	0		50.00
53.00	05300	ANESTHESIOLOGY	16,454	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	918,976	0		54.00
60.00	06000	LABORATORY	640,209	0		60.00
65.00	06500	RESPIRATORY THERAPY	297,010	0		65.00
66.00	06600	PHYSICAL THERAPY	414,327	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	93,366	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,014	0		68.00
69.00	06900	ELECTROCARDIOLOGY	429,146	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,905	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	196,490	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,733,372	1,697		73.00
73.01	03480	ONCOLOGY	325,955	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	188,386	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,200,694	221		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	512,899	33		92.00
200.00		Subtotal (see instructions)	8,826,780	1,951		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,826,780	1,951		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:41 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	0.197837	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.131730	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337566	0	0	0	0	54.00
60.00	06000	LABORATORY	0.446379	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.811395	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.637658	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.581708	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.547218	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.248142	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178696	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.158766	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370977	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.325200	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.637391	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.311706	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465222	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | 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	0.197837	0	249,815	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.131730	0	29,678	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337566	0	69,218	0	0	54.00
60.00	06000	LABORATORY	0.446379	0	155,267	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.811395	0	947	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.637658	0	5,272	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.581708	0	838	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.547218	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.248142	0	27,805	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178696	0	2,008	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.158766	0	4,016	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370977	0	61,493	0	0	73.00
73.01	03480	ONCOLOGY	0.325200	0	8,661	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.637391	0	18,684	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.311706	0	174,561	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465222	0	34,995	0	0	92.00
200.00		Subtotal (see instructions)		0	843,258	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	843,258	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	49,423	0		50.00
53.00	05300	ANESTHESIOLOGY	3,909	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,366	0		54.00
60.00	06000	LABORATORY	69,308	0		60.00
65.00	06500	RESPIRATORY THERAPY	768	0		65.00
66.00	06600	PHYSICAL THERAPY	3,362	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	487	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	6,900	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	359	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	638	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,812	0		73.00
73.01	03480	ONCOLOGY	2,817	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	11,909	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	54,412	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,280	0		92.00
200.00		Subtotal (see instructions)	266,750	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	266,750	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,892	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,702	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,100	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	180	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	10	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,217	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)	180	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,620,565	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,189	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)	414,613	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,205,952	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,205,952	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)	2,296.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,795,206	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,795,206	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,293,331	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,088,537	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)	413,424	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)	413,424	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)	602	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,296.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,382,674	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:41 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	805,765	6,620,565	0.121706	1,382,674	168,280	90.00
91.00	Nursing School cost	0	6,620,565	0.000000	1,382,674	0	91.00
92.00	Allied health cost	0	6,620,565	0.000000	1,382,674	0	92.00
93.00	All other Medical Education	0	6,620,565	0.000000	1,382,674	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,892	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,702	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,100	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	180	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	10	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)	13	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,620,565	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,189	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)	414,613	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,205,952	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,205,952	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)	2,296.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	29,858	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)	29,858	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	29,617	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	59,475	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	602	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,296.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,382,674	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	805,765	6,620,565	0.121706	1,382,674	168,280	90.00
91.00	Nursing School cost	0	6,620,565	0.000000	1,382,674	0	91.00
92.00	Allied health cost	0	6,620,565	0.000000	1,382,674	0	92.00
93.00	All other Medical Education	0	6,620,565	0.000000	1,382,674	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,536,399		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197837	2,726,476	539,398	50.00
53.00	05300	ANESTHESIOLOGY	0.131730	127,434	16,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337566	101,499	34,263	54.00
60.00	06000	LABORATORY	0.446379	346,455	154,650	60.00
65.00	06500	RESPIRATORY THERAPY	0.811395	178,946	145,196	65.00
66.00	06600	PHYSICAL THERAPY	0.637658	293,243	186,989	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.581708	135,691	78,933	67.00
68.00	06800	SPEECH PATHOLOGY	0.547218	13,352	7,306	68.00
69.00	06900	ELECTROCARDIOLOGY	0.248142	127,640	31,673	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178696	587,060	104,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.158766	4,057,619	644,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370977	930,893	345,340	73.00
73.01	03480	ONCOLOGY	0.325200	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.637391	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.311706	11,802	3,679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465222	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,638,110	2,293,331	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)		9,638,110		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3

Component CCN: 15-Z311 | Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197837	8,741	1,729	50.00
53.00	05300	ANESTHESIOLOGY	0.131730	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337566	8,024	2,709	54.00
60.00	06000	LABORATORY	0.446379	18,732	8,362	60.00
65.00	06500	RESPIRATORY THERAPY	0.811395	20,748	16,835	65.00
66.00	06600	PHYSICAL THERAPY	0.637658	63,096	40,234	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.581708	36,723	21,362	67.00
68.00	06800	SPEECH PATHOLOGY	0.547218	2,135	1,168	68.00
69.00	06900	ELECTROCARDIOLOGY	0.248142	876	217	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178696	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.158766	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370977	45,582	16,910	73.00
73.01	03480	ONCOLOGY	0.325200	2,748	894	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.637391	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.311706	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465222	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		207,405	110,420	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)		207,405		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		24,247		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197837	35,797	7,082	50.00
53.00	05300	ANESTHESIOLOGY	0.131730	1,672	220	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337566	8,118	2,740	54.00
60.00	06000	LABORATORY	0.446379	3,801	1,697	60.00
65.00	06500	RESPIRATORY THERAPY	0.811395	954	774	65.00
66.00	06600	PHYSICAL THERAPY	0.637658	2,088	1,331	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.581708	697	405	67.00
68.00	06800	SPEECH PATHOLOGY	0.547218	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.248142	438	109	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178696	975	174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.158766	22,578	3,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370977	15,650	5,806	73.00
73.01	03480	ONCOLOGY	0.325200	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.637391	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.311706	18,266	5,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465222	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		111,034	29,617	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)		111,034		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 8:41 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,828,731	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)	8,828,731	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)	8,917,018	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)	29,989	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,961,240	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)	3,925,789	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)	3,925,789	30.00
31.00	Primary payer payments	952	31.00
32.00	Subtotal (line 30 minus line 31)	3,924,837	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)	616,583	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	400,779	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	341,414	36.00
37.00	Subtotal (see instructions)	4,325,616	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)	4,325,616	40.00
40.01	Sequestration adjustment (see instructions)	86,512	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,813,811	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)	425,293	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 6/29/2020 8:41 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,246,048		3,041,011	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	08/14/2019	114,900	08/14/2019	772,800	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)		114,900		772,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,360,948		3,813,811	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		367,544		425,293	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,728,492		4,239,104	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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/29/2020 8:41 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		449,775		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)		449,775		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		61,695		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		511,470		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/29/2020 8:41 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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 6/29/2020 8:41 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)	417,558	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)	111,524	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	180	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)	529,082	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	529,082	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)	529,082	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,014	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	521,068	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)	1,292	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	840	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	521,908	0	19.00
19.01	Sequestration adjustment (see instructions)	10,438	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	449,775	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)	61,695	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	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 8:41 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,088,537	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,088,537	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,139,422	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,139,422	19.00
20.00	Deductibles (exclude professional component)	336,788	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,802,634	22.00
23.00	Coinsurance	12,958	23.00
24.00	Subtotal (line 22 minus line 23)	4,789,676	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	54,332	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	35,316	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,680	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,824,992	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	4,824,992	30.00
30.01	Sequestration adjustment (see instructions)	96,500	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	4,360,948	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)	367,544	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/29/2020 8:41 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	29,110,122	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,931,921	0	0	0	4.00
5.00	Other receivable	-1,133,802	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	720,147	0	0	0	7.00
8.00	Prepaid expenses	211,789	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)	31,840,177	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	7,712,716	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,872,457	0	0	0	17.00
18.00	Accumulated depreciation	-1,274,332	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	13,208,367	0	0	0	23.00
24.00	Accumulated depreciation	-10,347,252	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)	12,171,956	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	886,098	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	14,567,903	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,454,001	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	59,466,134	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,485,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,125,939	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,572,695	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,183,634	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,855,002	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	740,614	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,595,616	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,779,250	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,686,884				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)	39,686,884	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	59,466,134	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/29/2020 8:41 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		36,848,709		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,147,226				2.00
3.00	Total (sum of line 1 and line 2)		40,995,935		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		40,995,935		0		11.00
12.00	UNRESTRICTED FUND BALANCE	2,193		0		0	12.00
13.00	PERM RESTRICTED	115,348		0		0	13.00
14.00	TEMP RESTRICTED	1,191,510		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)		1,309,051		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39,686,884		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	UNRESTRICTED FUND BALANCE		0		12.00
13.00	PERM RESTRICTED		0		13.00
14.00	TEMP RESTRICTED		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: 15-1311 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/29/2020 8:41 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,301,499		4,301,499	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	162,070		162,070	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)	4,463,569		4,463,569	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,463,569		4,463,569	17.00
18.00	Ancillary services	18,658,394	63,503,268	82,161,662	18.00
19.00	Outpatient services	455,830	15,601,105	16,056,935	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	2,512,658	2,512,658	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,577,793	81,617,031	105,194,824	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,009,425		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)		39,009,425		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 6/29/2020 8:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	105,194,824	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,424,936	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,769,888	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,009,425	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,760,463	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	2,386,763	24.00
25.00	Total other income (sum of lines 6-24)	2,386,763	25.00
26.00	Total (line 5 plus line 25)	4,147,226	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,147,226	29.00