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: 15-1312	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 8:40 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/29/2020 Time: 8:40 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 WHITE HOSPITAL (15-1312) 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) TODD WILLIAMS
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	363,310	-292,509	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	22,563	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	385,873	-292,509	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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:40 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 720 SOUTH SIXTH STREET	PO Box:			1.00
2.00	City: MONTICELLO	State: IN	Zip Code: 47960	County: WHITE	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 WHITE HOSPITAL	151312	99915	1	07/01/1966	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 WHITE HOSPITAL	15Z312	99915		02/16/1990	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	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 8:40 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:40 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:40 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:40 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 8:40 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	39,714	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 8:40 am

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS		Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:			142.00
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46202	143.00

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

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

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

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

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

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

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

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	108	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/29/2020 8:40 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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:40 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.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1312	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:40 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.	GOVERNMENT PROGRAMS DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 6/29/2020 8:40 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	41,088.00	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	41,088.00	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	41,088.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:40 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)	1,014	12	1,712			1.00
2.00	HMO and other (see instructions)	278	136				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	152	0	152			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	376			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,166	12	2,240			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)	1,166	12	2,240	0.00	137.34	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			1			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	137.34	27.00
28.00	Observation Bed Days		17	571			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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:40 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	318	5	526	1.00
2.00	HMO and other (see instructions)			66	45		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	318	5	526	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 6/29/2020 8:40 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)	0.314386	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,181,338	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	13,761,177	6.00
7.00	Medicaid cost (line 1 times line 6)	4,326,321	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)	3,144,983	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)	3,144,983	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)	2,859,756	71,297	2,931,053	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	899,067	71,297	970,364	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,211	0	1,211	22.00
23.00	Cost of charity care (line 21 minus line 22)	897,856	71,297	969,153	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,366,910	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	670,812	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,032,020	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,334,890	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,095,265	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,064,418	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,209,401	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:40 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		1,599,652	1,599,652	-1,588,075	11,577	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	2,466,396	2,466,396	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB		0	0	224,356	224,356	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	93	50,930	51,023	1,528,309	1,579,332	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	615,168	7,359,972	7,975,140	-454,788	7,520,352	5.00
7.00	00700	OPERATION OF PLANT	353,809	1,907,976	2,261,785	-1,865,791	395,994	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	1,689,350	1,689,350	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	0	0	330,942	330,942	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	68,164	68,164	8.00
9.00	00900	HOUSEKEEPING	311,032	267,561	578,593	-193,130	385,463	9.00
10.00	01000	DIETARY	483,191	356,031	839,222	-311,543	527,679	10.00
11.00	01100	CAFETERIA	0	0	0	149,825	149,825	11.00
13.00	01300	NURSING ADMINISTRATION	678,286	219,941	898,227	105,680	1,003,907	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40,786	40,786	619,130	659,916	14.00
15.00	01500	PHARMACY	366,989	3,027,645	3,394,634	-2,727,103	667,531	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,346,846	1,003,250	2,350,096	-458,677	1,891,419	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	459,387	881,252	1,340,639	-328,481	1,012,158	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	314,533	384,618	699,151	-265,070	434,081	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	80,994	61,253	142,247	-35,848	106,399	55.00
56.00	05600	RADIOISOTOPE	125,439	52,158	177,597	-43,311	134,286	56.00
57.00	05700	CT SCAN	361,752	256,364	618,116	-223,004	395,112	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	127,789	84,102	211,891	-67,818	144,073	58.00
60.00	06000	LABORATORY	0	1,259,696	1,259,696	10	1,259,706	60.00
66.00	06600	PHYSICAL THERAPY	385,631	112,988	498,619	-78,131	420,488	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,917	30,427	148,344	-18,821	129,523	67.00
68.00	06800	SPEECH PATHOLOGY	68,545	20,194	88,739	-14,518	74,221	68.00
69.00	06900	ELECTROCARDIOLOGY	110,960	38,816	149,776	-26,606	123,170	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	22,870	22,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,056	9,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	389,094	389,094	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	2,306,631	2,306,631	73.01
76.00	03160	CARDIOPULMONARY	467,921	262,162	730,083	-162,858	567,225	76.00
76.97	07697	CARDIAC REHABILITATION	21,760	159,262	181,022	-955	180,067	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	117,832	87,094	204,926	-40,570	164,356	90.00
91.00	09100	EMERGENCY	1,134,144	1,803,742	2,937,886	-432,036	2,505,850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,050,018	21,327,872	29,377,890	572,679	29,950,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,349	24,510	103,859	-17,401	86,458	192.00
192.02	19202	MOB	0	555,277	555,277	-555,278	-1	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	8,129,367	21,907,659	30,037,026	0	30,037,026	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:40 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	26,225	37,802		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	206,340	2,672,736		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	293,636	517,992		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	282,819	1,862,151		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-697,898	6,822,454		5.00
7.00	00700	OPERATION OF PLANT	0	395,994		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	36,780	1,726,130		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	330,942		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,164		8.00
9.00	00900	HOUSEKEEPING	0	385,463		9.00
10.00	01000	DIETARY	-136,934	390,745		10.00
11.00	01100	CAFETERIA	-59,461	90,364		11.00
13.00	01300	NURSING ADMINISTRATION	23,223	1,027,130		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-16,893	643,023		14.00
15.00	01500	PHARMACY	202,114	869,645		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-219,866	1,671,553		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-217,930	794,228		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-252	433,829		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	106,399		55.00
56.00	05600	RADIOISOTOPE	0	134,286		56.00
57.00	05700	CT SCAN	0	395,112		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	144,073		58.00
60.00	06000	LABORATORY	0	1,259,706		60.00
66.00	06600	PHYSICAL THERAPY	0	420,488		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	129,523		67.00
68.00	06800	SPEECH PATHOLOGY	0	74,221		68.00
69.00	06900	ELECTROCARDIOLOGY	0	123,170		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,870		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,056		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	389,094		73.00
73.01	07301	ONCOLOGY DRUGS	0	2,306,631		73.01
76.00	03160	CARDIOPULMONARY	99,894	667,119		76.00
76.97	07697	CARDIAC REHABILITATION	0	180,067		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	164,356		90.00
91.00	09100	EMERGENCY	18,230	2,524,080		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-159,973	29,790,596		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	86,458		192.00
192.02	19202	MOB	0	-1		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-159,973	29,877,053		200.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:40 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	102,981	46,844	1.00
	0		102,981	46,844	
	B - DRUGS EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	389,094	1.00
2.00	ONCOLOGY DRUGS	73.01	0	2,306,631	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
	0		0	2,695,725	
	C - MEDICAL SUPPLIES AND REBATES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	623,592	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	22,870	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,056	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	61	4.00
5.00	LABORATORY	60.00	0	10	5.00
6.00	MOB	192.02	0	20	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	655,609	
	D - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	68,164	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	68,164	
	E - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,412,682	1.00
2.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	248,594	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

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:40 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
22.00		0.00	0	0		22.00
	0		0	1,661,276		
	F - OTHER CAPITAL EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,029,475		1.00
2.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	24,239		2.00
3.00	MOB	192.02	0	24,238		3.00
	TOTALS		0	1,077,952		
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT - HOSPITAL	7.01	0	1,689,350		1.00
2.00	OPERATION OF PLANT - TLMOB	7.02	0	330,942		2.00
	0		0	2,020,292		
	H - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,530,149		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	1,530,149		
	I - HOUSEKEEPING SUPPLIES					
1.00	HOUSEKEEPING	9.00	0	6,355		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	0		0	6,355		
	J - NON-CAPITAL EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	71		1.00
	TOTALS		0	71		
	K - CNO					
1.00	NURSING ADMINISTRATION	13.00	198,876	0		1.00
	TOTALS		198,876	0		
500.00	Grand Total: Increases		301,857	9,762,437		500.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:40 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	102,981	46,844	0		1.00
	0		102,981	46,844			
	B - DRUGS EXPENSE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,790	0		1.00
2.00	PHARMACY	15.00	0	2,640,637	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	6,886	0		3.00
4.00	OPERATING ROOM	50.00	0	4,770	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,465	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	17,212	0		6.00
7.00	RADIOISOTOPE	56.00	0	210	0		7.00
8.00	CT SCAN	57.00	0	5,293	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	11	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	5	0		11.00
12.00	CARDIOPULMONARY	76.00	0	2,187	0		12.00
13.00	CLINIC	90.00	0	4,197	0		13.00
14.00	EMERGENCY	91.00	0	10,050	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11	0		15.00
	0		0	2,695,725			
	C - MEDICAL SUPPLIES AND REBATES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	426	0		1.00
2.00	OPERATION OF PLANT	7.00	0	24,938	0		2.00
3.00	HOUSEKEEPING	9.00	0	18,654	0		3.00
4.00	DIETARY	10.00	0	1,292	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	38	0		5.00
6.00	PHARMACY	15.00	0	10,514	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	97,849	0		7.00
8.00	OPERATING ROOM	50.00	0	168,266	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,302	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	86	0		10.00
11.00	RADIOISOTOPE	56.00	0	9,405	0		11.00
12.00	CT SCAN	57.00	0	65,560	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10,447	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	4,620	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	224	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	9,640	0		16.00
17.00	CARDIOPULMONARY	76.00	0	47,860	0		17.00
18.00	CARDIAC REHABILITATION	76.97	0	60	0		18.00
19.00	CLINIC	90.00	0	7,660	0		19.00
20.00	EMERGENCY	91.00	0	172,197	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,571	0		21.00
	0		0	655,609			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	62,293	0		1.00
2.00	DIETARY	10.00	0	5,846	0		2.00
3.00	OPERATING ROOM	50.00	0	25	0		3.00
	0		0	68,164			
	E - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	558,529	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,414	9		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	164,736	0		3.00
4.00	OPERATION OF PLANT	7.00	0	67,577	0		4.00
5.00	DIETARY	10.00	0	39,658	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,672	0		6.00
7.00	PHARMACY	15.00	0	35,123	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	69,788	0		8.00
9.00	OPERATING ROOM	50.00	0	79,954	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	186,938	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,494	0		11.00
12.00	RADIOISOTOPE	56.00	0	17,047	0		12.00
13.00	CT SCAN	57.00	0	86,549	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	40,443	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	262	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	60	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	3,895	0		17.00
18.00	CARDIOPULMONARY	76.00	0	4,385	0		18.00
19.00	CLINIC	90.00	0	14	0		19.00
20.00	EMERGENCY	91.00	0	47,704	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,440	0		21.00
22.00	MOB	192.02	0	248,594	0		22.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:40 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	0		0	1,661,276			
	F - OTHER CAPITAL EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,029,475	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	24,239	12		2.00
3.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	24,238	13		3.00
	TOTALS		0	1,077,952			
	G - OPERATION OF PLANT						
1.00	OPERATION OF PLANT	7.00	0	1,689,350	0		1.00
2.00	MOB	192.02	0	330,942	0		2.00
	0		0	2,020,292			
	H - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	67,068	0		1.00
2.00	OPERATION OF PLANT	7.00	0	83,926	0		2.00
3.00	HOUSEKEEPING	9.00	0	118,538	0		3.00
4.00	DIETARY	10.00	0	109,658	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	93,158	0		5.00
6.00	PHARMACY	15.00	0	40,236	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	283,863	0		7.00
8.00	OPERATING ROOM	50.00	0	75,450	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	71,282	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	15,056	0		10.00
11.00	RADIOISOTOPE	56.00	0	16,602	0		11.00
12.00	CT SCAN	57.00	0	65,602	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	16,917	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	73,248	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	18,537	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	14,515	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	13,066	0		17.00
18.00	CARDIOPULMONARY	76.00	0	108,417	0		18.00
19.00	CARDIAC REHABILITATION	76.97	0	895	0		19.00
20.00	CLINIC	90.00	0	28,672	0		20.00
21.00	EMERGENCY	91.00	0	202,064	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,379	0		22.00
	0		0	1,530,149			
	I - HOUSEKEEPING SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1	0		1.00
2.00	DIETARY	10.00	0	5,264	0		2.00
3.00	PHARMACY	15.00	0	593	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	291	0		4.00
5.00	OPERATING ROOM	50.00	0	16	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	83	0		6.00
7.00	RADIOISOTOPE	56.00	0	47	0		7.00
8.00	SPEECH PATHOLOGY	68.00	0	3	0		8.00
9.00	CARDIOPULMONARY	76.00	0	9	0		9.00
10.00	CLINIC	90.00	0	27	0		10.00
11.00	EMERGENCY	91.00	0	21	0		11.00
	0		0	6,355			
	J - NON-CAPITAL EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71	12		1.00
	TOTALS		0	71			
	K - CNO						
1.00	ADMINISTRATIVE & GENERAL	5.00	198,876	0	0		1.00
	TOTALS		198,876	0			
500.00	Grand Total: Decreases		301,857	9,762,437			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I Date/Time Prepared: 6/29/2020 8:40 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	954,570	0	0	0	0	1.00
2.00	Land Improvements	891,287	0	0	0	77,727	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	38,596,503	0	0	0	137,041	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,190,027	816,080	0	816,080	14,936	6.00
7.00	HIT designated Assets	15,000	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,647,387	816,080	0	816,080	229,704	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	46,647,387	816,080	0	816,080	229,704	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	954,570	0	1.00
2.00	Land Improvements	813,560	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	38,459,462	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,991,171	2,260,869	6.00
7.00	HIT designated Assets	15,000	15,000	7.00
8.00	Subtotal (sum of lines 1-7)	47,233,763	2,275,869	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	47,233,763	2,275,869	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 6/29/2020 8:40 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	570,106	0	1,029,475	71	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	570,106	0	1,029,475	71	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	1,599,652	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	1.02
3.00	Total (sum of lines 1-2)	0	1,599,652	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III | Date/Time Prepared: 6/29/2020 8:40 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	1,768,130	0	1,768,130	0.037434	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	30,530,430	0	30,530,430	0.646368	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	14,935,204	0	14,935,204	0.316198	0	1.02
3.00	Total (sum of lines 1-2)	47,233,764	0	47,233,764	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	37,802	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,605,669	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	542,230	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	2,185,701	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	37,802	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,042,828	24,239	0	0	2,672,736	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	-24,238	0	517,992	1.02
3.00	Total (sum of lines 1-2)	1,042,828	24,239	-24,238	0	3,228,530	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:40 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 - HOSPITAL (chapter 2)	B	-653,840	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-557,840			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	4,275,402			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-49,839	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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	*** Cost Center Deleted ***	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	26,225	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	104,068	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	293,636	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:40 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	-8,609	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	32.00
33.00	EMPLOYEE BENEFITS	A	-1,530,471	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	LOSS ON ABANDONMENT	A	97,528	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.01
33.02	MARKETING	A	-2,244	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MEDICAID HAF FEES	A	-1,781,337	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-5,076	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-8,047	DIETARY	10.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-9,622	CAFETERIA	11.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-3,740	NURSING ADMINISTRATION	13.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-16,893	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-5,638	PHARMACY	15.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-252	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	WIC PROGRAM COSTS	A	-213,039	DIETARY	10.00	0	33.11
33.12	WIC PROGRAM BENEFIT COSTS	A	-31,405	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	ACCRUED PTO - GENERAL	A	-60,170	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	CONTRIBUTION EXPENSE	A	-13,000	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	TELEPHONE EXPENSE	A	-5,216	ADULTS & PEDIATRICS	30.00	0	33.15
33.16	TELEPHONE EXPENSE	A	-554	OPERATING ROOM	50.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-159,973				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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:40 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	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	1,696,668	1,029,475	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,844,695	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,829,519	4,281,046	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	POOLED CAPITAL - H.O.	237,084	0	3.01
3.02	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	0	31,271	3.02
4.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,151,670	773,298	4.00
4.01	7.01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	89,772	52,992	4.01
4.02	10.00	DIETARY	RELATED PARTY	84,152	0	4.02
4.03	13.00	NURSING ADMINISTRATION	RELATED PARTY	58,234	0	4.03
4.04	15.00	PHARMACY	RELATED PARTY	424,038	216,286	4.04
4.05	30.00	ADULTS & PEDIATRICS	RELATED PARTY	202,610	84,011	4.05
4.06	50.00	OPERATING ROOM	RELATED PARTY	260,263	253,048	4.06
4.07	76.00	CARDIOPULMONARY	RELATED PARTY	136,455	36,561	4.07
4.08	91.00	EMERGENCY	RELATED PARTY	137,939	119,709	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	152	152	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	10,569	10,569	4.10
4.11	7.01	OPERATION OF PLANT - HOSPITA	SHARED EMPLOYEES	39,283	39,283	4.11
4.12	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	333,249	333,249	4.12
4.13	50.00	OPERATING ROOM	SHARED EMPLOYEES	224,591	224,591	4.13
4.14	60.00	LABORATORY	SHARED EMPLOYEES	1,220,567	1,220,567	4.14
4.15	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	28,821	28,821	4.15
4.16	192.00	PHYSICIANS' PRIVATE OFFICES	SHARED EMPLOYEES	28,625	28,625	4.16
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,038,956	8,763,554	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	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		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: 15-1312	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/29/2020 8:40 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	667,193	11		1.00
2.00	1,844,695	0		2.00
3.00	548,473	0		3.00
3.01	237,084	0		3.01
3.02	-31,271	0		3.02
4.00	378,372	0		4.00
4.01	36,780	0		4.01
4.02	84,152	0		4.02
4.03	58,234	0		4.03
4.04	207,752	0		4.04
4.05	118,599	0		4.05
4.06	7,215	0		4.06
4.07	99,894	0		4.07
4.08	18,230	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
4.15	0	0		4.15
4.16	0	0		4.16
5.00	4,275,402			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			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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/29/2020 8:40 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	30.00	ADULTS & PEDIATRICS	333,249	333,249	0	0	0	1.00
2.00	50.00	OPERATING ROOM	224,591	224,591	0	0	0	2.00
3.00	91.00	EMERGENCY	1,158,969	0	1,158,969	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,716,809	557,840	1,158,969		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	333,249		1.00
2.00	50.00	OPERATING ROOM	0	0	0	224,591		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	557,840		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	37,802	37,802				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	2,672,736	0	2,672,736			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	517,992	0	0	517,992		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,862,151	0	0	0	1,862,151	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,822,454	3,476	109,371	88,359	95,359	5.00
7.00	00700	OPERATION OF PLANT	395,994	0	0	0	81,046	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,726,130	5,226	609,141	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	330,942	2,842	0	98,981	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	68,164	168	19,615	0	0	8.00
9.00	00900	HOUSEKEEPING	385,463	561	60,101	1,583	71,247	9.00
10.00	01000	DIETARY	390,745	1,285	0	44,735	87,094	10.00
11.00	01100	CAFETERIA	90,364	612	0	21,298	23,590	11.00
13.00	01300	NURSING ADMINISTRATION	1,027,130	544	32,119	9,344	200,929	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	643,023	1,487	173,376	0	0	14.00
15.00	01500	PHARMACY	869,645	635	74,045	0	84,065	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,671,553	4,106	478,621	0	308,523	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	794,228	2,690	313,611	0	105,230	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	433,829	1,019	118,760	0	72,049	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	106,399	209	24,403	0	18,553	55.00
56.00	05600	RADIOISOTOPE	134,286	144	16,826	0	28,734	56.00
57.00	05700	CT SCAN	395,112	197	22,962	0	82,865	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	144,073	278	32,398	0	29,272	58.00
60.00	06000	LABORATORY	1,259,706	925	107,791	0	0	60.00
66.00	06600	PHYSICAL THERAPY	420,488	896	104,444	0	88,335	66.00
67.00	06700	OCCUPATIONAL THERAPY	129,523	71	8,320	0	27,011	67.00
68.00	06800	SPEECH PATHOLOGY	74,221	33	3,904	0	15,701	68.00
69.00	06900	ELECTROCARDIOLOGY	123,170	213	24,821	0	25,417	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,870	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,056	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	389,094	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	2,306,631	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	667,119	421	49,085	0	107,185	76.00
76.97	07697	CARDIAC REHABILITATION	180,067	510	0	17,772	4,984	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	164,356	487	56,800	0	26,991	90.00
91.00	09100	EMERGENCY	2,524,080	1,992	232,222	0	259,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,790,596	31,027	2,672,736	282,072	1,843,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86,458	1,189	0	41,403	18,176	192.00
192.02	19202	MOB	-1	4,412	0	153,628	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,174	0	40,889	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,877,053	37,802	2,672,736	517,992	1,862,151	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,119,019	7,119,019				5.00
7.00	00700	OPERATION OF PLANT	477,040	149,224	626,264			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,340,497	732,138	95,331	3,167,966		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	432,765	135,375	51,859	0	619,999	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	87,947	27,511	3,070	31,798	0	8.00
9.00	00900	HOUSEKEEPING	518,955	162,336	10,235	97,428	2,968	9.00
10.00	01000	DIETARY	523,859	163,870	23,438	0	83,881	10.00
11.00	01100	CAFETERIA	135,864	42,500	11,159	0	39,936	11.00
13.00	01300	NURSING ADMINISTRATION	1,270,066	397,293	9,922	52,067	17,521	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	817,886	255,845	27,133	281,058	0	14.00
15.00	01500	PHARMACY	1,028,390	321,694	11,588	120,034	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,462,803	770,397	74,904	775,886	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,215,759	380,305	49,080	508,391	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	625,657	195,714	18,586	192,521	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	149,564	46,786	3,819	39,559	0	55.00
56.00	05600	RADIOISOTOPE	179,990	56,303	2,633	27,277	0	56.00
57.00	05700	CT SCAN	501,136	156,762	3,594	37,223	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	206,021	64,446	5,070	52,519	0	58.00
60.00	06000	LABORATORY	1,368,422	428,060	16,869	174,738	0	60.00
66.00	06600	PHYSICAL THERAPY	614,163	192,118	16,345	169,313	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,925	51,591	1,302	13,488	0	67.00
68.00	06800	SPEECH PATHOLOGY	93,859	29,360	611	6,329	0	68.00
69.00	06900	ELECTROCARDIOLOGY	173,621	54,311	3,885	40,237	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,870	7,154	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,056	2,833	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	389,094	121,714	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	2,306,631	721,544	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	823,810	257,698	7,682	79,570	0	76.00
76.97	07697	CARDIAC REHABILITATION	203,333	63,605	9,311	0	33,323	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	248,634	77,776	8,889	92,078	0	90.00
91.00	09100	EMERGENCY	3,018,089	944,107	36,343	376,452	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,529,725	7,010,370	502,658	3,167,966	177,629	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	147,226	46,054	21,692	0	77,633	192.00
192.02	19202	MOB	158,039	49,437	80,491	0	288,067	192.02
192.03	19203	ARNETT SURGERY OFFICE	42,063	13,158	21,423	0	76,670	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,877,053	7,119,019	626,264	3,167,966	619,999	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	150,326					8.00
9.00	00900	HOUSEKEEPING	0	791,922				9.00
10.00	01000	DIETARY	0	25,424	820,472			10.00
11.00	01100	CAFETERIA	0	12,025	0	241,484		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,123	0	22,271	1,773,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,123	0	0	0	14.00
15.00	01500	PHARMACY	0	21,988	0	9,515	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	150,326	179,686	820,472	51,852	954,510	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	97,917	0	15,973	177,403	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,295	0	11,331	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,528	0	2,206	0	55.00
56.00	05600	RADIOISOTOPE	0	4,466	0	3,585	0	56.00
57.00	05700	CT SCAN	0	6,184	0	12,112	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,933	0	4,528	0	58.00
60.00	06000	LABORATORY	0	30,234	0	21,213	0	60.00
66.00	06600	PHYSICAL THERAPY	0	25,080	0	12,434	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,061	0	2,758	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,031	0	1,586	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,953	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	29,890	0	17,237	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	10,651	0	781	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	22,675	0	5,010	56,749	90.00
91.00	09100	EMERGENCY	0	103,070	0	39,439	584,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	150,326	628,384	820,472	237,784	1,773,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,860	0	3,700	0	192.00
192.02	19202	MOB	0	134,678	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	150,326	791,922	820,472	241,484	1,773,263	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	1,386,045					14.00
15.00	01500	PHARMACY	23,168	1,536,377				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	197,954	3,884	0	6,442,674	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	318,278	2,691	0	2,765,797	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,170	876	0	1,086,150	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	214	19	0	248,695	0	55.00
56.00	05600	RADIOISOTOPE	17,140	118	0	291,512	0	56.00
57.00	05700	CT SCAN	133,421	83	0	850,515	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,110	6	0	362,633	0	58.00
60.00	06000	LABORATORY	0	0	0	2,039,536	0	60.00
66.00	06600	PHYSICAL THERAPY	8,894	0	0	1,038,347	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	256	0	0	236,381	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	132,776	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,882	3	0	284,892	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	175,257	0	0	205,281	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,124	0	0	30,013	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	219,491	0	730,299	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	1,301,193	0	4,329,368	0	73.01
76.00	03160	CARDIOPULMONARY	96,982	3	0	1,312,872	0	76.00
76.97	07697	CARDIAC REHABILITATION	476	0	0	321,480	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,514	2,368	0	526,693	0	90.00
91.00	09100	EMERGENCY	340,919	5,642	0	5,448,662	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,382,759	1,536,377	0	28,684,576	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,286	0	0	328,451	0	192.00
192.02	19202	MOB	0	0	0	710,712	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	153,314	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,386,045	1,536,377	0	29,877,053	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
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 - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,442,674		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,765,797		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,086,150		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	248,695		55.00
56.00	05600	RADIOISOTOPE	291,512		56.00
57.00	05700	CT SCAN	850,515		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	362,633		58.00
60.00	06000	LABORATORY	2,039,536		60.00
66.00	06600	PHYSICAL THERAPY	1,038,347		66.00
67.00	06700	OCCUPATIONAL THERAPY	236,381		67.00
68.00	06800	SPEECH PATHOLOGY	132,776		68.00
69.00	06900	ELECTROCARDIOLOGY	284,892		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	205,281		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,013		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	730,299		73.00
73.01	07301	ONCOLOGY DRUGS	4,329,368		73.01
76.00	03160	CARDIOPULMONARY	1,312,872		76.00
76.97	07697	CARDIAC REHABILITATION	321,480		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	526,693		90.00
91.00	09100	EMERGENCY	5,448,662		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,684,576		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	328,451		192.00
192.02	19202	MOB	710,712		192.02
192.03	19203	ARNETT SURGERY OFFICE	153,314		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	29,877,053		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	237,084	3,476	109,371	88,359	438,290	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	5,226	609,141	0	614,367	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	2,842	0	98,981	101,823	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	168	19,615	0	19,783	8.00
9.00	00900	HOUSEKEEPING	0	561	60,101	1,583	62,245	9.00
10.00	01000	DIETARY	0	1,285	0	44,735	46,020	10.00
11.00	01100	CAFETERIA	0	612	0	21,298	21,910	11.00
13.00	01300	NURSING ADMINISTRATION	0	544	32,119	9,344	42,007	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,487	173,376	0	174,863	14.00
15.00	01500	PHARMACY	0	635	74,045	0	74,680	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,106	478,621	0	482,727	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,690	313,611	0	316,301	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,019	118,760	0	119,779	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	209	24,403	0	24,612	55.00
56.00	05600	RADIOISOTOPE	0	144	16,826	0	16,970	56.00
57.00	05700	CT SCAN	0	197	22,962	0	23,159	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	278	32,398	0	32,676	58.00
60.00	06000	LABORATORY	0	925	107,791	0	108,716	60.00
66.00	06600	PHYSICAL THERAPY	0	896	104,444	0	105,340	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	71	8,320	0	8,391	67.00
68.00	06800	SPEECH PATHOLOGY	0	33	3,904	0	3,937	68.00
69.00	06900	ELECTROCARDIOLOGY	0	213	24,821	0	25,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	421	49,085	0	49,506	76.00
76.97	07697	CARDIAC REHABILITATION	0	510	0	17,772	18,282	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	487	56,800	0	57,287	90.00
91.00	09100	EMERGENCY	0	1,992	232,222	0	234,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	237,084	31,027	2,672,736	282,072	3,222,919	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,189	0	41,403	42,592	192.00
192.02	19202	MOB	0	4,412	0	153,628	158,040	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,174	0	40,889	42,063	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	237,084	37,802	2,672,736	517,992	3,465,614	202.00

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		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	438,290				5.00
7.00	00700	OPERATION OF PLANT	0	9,187	9,187			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	45,076	1,397	660,840		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	8,335	761	0	110,919	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,694	45	6,633	0	8.00
9.00	00900	HOUSEKEEPING	0	9,995	150	20,324	531	9.00
10.00	01000	DIETARY	0	10,089	344	0	15,007	10.00
11.00	01100	CAFETERIA	0	2,617	164	0	7,145	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,460	146	10,861	3,135	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,752	398	58,629	0	14.00
15.00	01500	PHARMACY	0	19,806	170	25,039	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	47,431	1,099	161,849	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,414	720	106,051	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,050	273	40,160	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,880	56	8,252	0	55.00
56.00	05600	RADIOISOTOPE	0	3,466	39	5,690	0	56.00
57.00	05700	CT SCAN	0	9,651	53	7,765	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,968	74	10,956	0	58.00
60.00	06000	LABORATORY	0	26,354	247	36,450	0	60.00
66.00	06600	PHYSICAL THERAPY	0	11,828	240	35,319	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,176	19	2,814	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,808	9	1,320	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,344	57	8,394	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	440	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	174	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,494	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	44,423	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	15,866	113	16,598	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,916	137	0	5,962	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,788	130	19,208	0	90.00
91.00	09100	EMERGENCY	0	58,119	533	78,528	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	431,601	7,374	660,840	31,780	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,835	318	0	13,889	192.00
192.02	19202	MOB	0	3,044	1,181	0	51,534	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	810	314	0	13,716	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	438,290	9,187	660,840	110,919	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	28,155					8.00
9.00	00900	HOUSEKEEPING	0	93,245				9.00
10.00	01000	DIETARY	0	2,994	74,454			10.00
11.00	01100	CAFETERIA	0	1,416	0	33,252		11.00
13.00	01300	NURSING ADMINISTRATION	0	485	0	3,067	84,161	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	485	0	0	0	14.00
15.00	01500	PHARMACY	0	2,589	0	1,310	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,155	21,157	74,454	7,139	45,302	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,529	0	2,199	8,420	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,803	0	1,560	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	769	0	304	0	55.00
56.00	05600	RADIOISOTOPE	0	526	0	494	0	56.00
57.00	05700	CT SCAN	0	728	0	1,668	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,052	0	623	0	58.00
60.00	06000	LABORATORY	0	3,560	0	2,921	0	60.00
66.00	06600	PHYSICAL THERAPY	0	2,953	0	1,712	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	243	0	380	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	121	0	218	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	544	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	3,519	0	2,374	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,254	0	108	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,670	0	690	2,693	90.00
91.00	09100	EMERGENCY	0	12,136	0	5,431	27,746	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,155	73,989	74,454	32,742	84,161	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,398	0	510	0	192.00
192.02	19202	MOB	0	15,858	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,155	93,245	74,454	33,252	84,161	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	250,127					14.00
15.00	01500	PHARMACY	4,181	127,775				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,723	323	0	905,359	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,437	224	0	526,295	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,655	73	0	179,353	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	39	2	0	36,914	0	55.00
56.00	05600	RADIOISOTOPE	3,093	10	0	30,288	0	56.00
57.00	05700	CT SCAN	24,077	7	0	67,108	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,810	1	0	53,160	0	58.00
60.00	06000	LABORATORY	0	0	0	178,248	0	60.00
66.00	06600	PHYSICAL THERAPY	1,605	0	0	158,997	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	46	0	0	15,069	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,413	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,603	0	0	38,976	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,627	0	0	32,067	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,271	0	0	3,445	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,254	0	25,748	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	108,215	0	152,638	0	73.01
76.00	03160	CARDIOPULMONARY	17,501	0	0	105,477	0	76.00
76.97	07697	CARDIAC REHABILITATION	86	0	0	29,745	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,258	197	0	89,921	0	90.00
91.00	09100	EMERGENCY	61,522	469	0	478,698	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	249,534	127,775	0	3,114,919	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	593	0	0	64,135	0	192.00
192.02	19202	MOB	0	0	0	229,657	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	56,903	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	250,127	127,775	0	3,465,614	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
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 - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	905,359		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	526,295		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,353		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	36,914		55.00
56.00	05600	RADIOISOTOPE	30,288		56.00
57.00	05700	CT SCAN	67,108		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53,160		58.00
60.00	06000	LABORATORY	178,248		60.00
66.00	06600	PHYSICAL THERAPY	158,997		66.00
67.00	06700	OCCUPATIONAL THERAPY	15,069		67.00
68.00	06800	SPEECH PATHOLOGY	7,413		68.00
69.00	06900	ELECTROCARDIOLOGY	38,976		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,067		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,445		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,748		73.00
73.01	07301	ONCOLOGY DRUGS	152,638		73.01
76.00	03160	CARDIOPULMONARY	105,477		76.00
76.97	07697	CARDIAC REHABILITATION	29,745		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	89,921		90.00
91.00	09100	EMERGENCY	478,698		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,114,919		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,135		192.00
192.02	19202	MOB	229,657		192.02
192.03	19203	ARNETT SURGERY OFFICE	56,903		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,465,614		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	94,809					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	57,501				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	37,308			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	8,129,274		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,717	2,353	6,364	416,292	-7,119,019	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	353,809	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	13,105	13,105	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	7,129	0	7,129	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	422	422	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,407	1,293	114	311,032	0	9.00
10.00	01000	DIETARY	3,222	0	3,222	380,210	0	10.00
11.00	01100	CAFETERIA	1,534	0	1,534	102,981	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,364	691	673	877,162	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	0	0	14.00
15.00	01500	PHARMACY	1,593	1,593	0	366,989	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,297	10,297	0	1,346,846	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,747	6,747	0	459,387	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555	2,555	0	314,533	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	525	525	0	80,994	0	55.00
56.00	05600	RADIOISOTOPE	362	362	0	125,439	0	56.00
57.00	05700	CT SCAN	494	494	0	361,752	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	697	697	0	127,789	0	58.00
60.00	06000	LABORATORY	2,319	2,319	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,247	2,247	0	385,631	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	179	0	117,917	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	68,545	0	68.00
69.00	06900	ELECTROCARDIOLOGY	534	534	0	110,960	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,056	1,056	0	467,921	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,280	0	1,280	21,760	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,222	1,222	0	117,832	0	90.00
91.00	09100	EMERGENCY	4,996	4,996	0	1,134,144	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,817	57,501	20,316	8,049,925	-7,119,019	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,982	0	2,982	79,349	0	192.00
192.02	19202	MOB	11,065	0	11,065	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	2,945	0	2,945	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	37,802	2,672,736	517,992	1,862,151		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.398717	46.481557	13.884207	0.229067		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,758,034					5.00
7.00	00700	OPERATION OF PLANT	477,040	86,092				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,340,497	13,105	42,043			7.01
7.02	00702	OPERATION OF PLANT - TLMOB	432,765	7,129	0	23,815		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	87,947	422	422	0	2,240	8.00
9.00	00900	HOUSEKEEPING	518,955	1,407	1,293	114	0	9.00
10.00	01000	DIETARY	523,859	3,222	0	3,222	0	10.00
11.00	01100	CAFETERIA	135,864	1,534	0	1,534	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,270,066	1,364	691	673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	817,886	3,730	3,730	0	0	14.00
15.00	01500	PHARMACY	1,028,390	1,593	1,593	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,462,803	10,297	10,297	0	2,240	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,215,759	6,747	6,747	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	625,657	2,555	2,555	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	149,564	525	525	0	0	55.00
56.00	05600	RADIOISOTOPE	179,990	362	362	0	0	56.00
57.00	05700	CT SCAN	501,136	494	494	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	206,021	697	697	0	0	58.00
60.00	06000	LABORATORY	1,368,422	2,319	2,319	0	0	60.00
66.00	06600	PHYSICAL THERAPY	614,163	2,247	2,247	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,925	179	179	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	93,859	84	84	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	173,621	534	534	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,870	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,056	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	389,094	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	2,306,631	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	823,810	1,056	1,056	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	203,333	1,280	0	1,280	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	248,634	1,222	1,222	0	0	90.00
91.00	09100	EMERGENCY	3,018,089	4,996	4,996	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,410,706	69,100	42,043	6,823	2,240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	147,226	2,982	0	2,982	0	192.00
192.02	19202	MOB	158,039	11,065	0	11,065	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	42,063	2,945	0	2,945	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,119,019	626,264	3,167,966	619,999	150,326	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.312813	7.274358	75.350617	26.033970	67.109821	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	438,290	9,187	660,840	110,919	28,155	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.019259	0.106711	15.718193	4.657527	12.569196	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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			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 - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,305					9.00
10.00	01000	DIETARY	74	2,240				10.00
11.00	01100	CAFETERIA	35	0	10,507			11.00
13.00	01300	NURSING ADMINISTRATION	12	0	969	76,087		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12	0	0	0	692,552	14.00
15.00	01500	PHARMACY	64	0	414	0	11,576	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	523	2,240	2,256	40,956	98,910	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	285	0	695	7,612	159,031	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94	0	493	0	4,582	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	19	0	96	0	107	55.00
56.00	05600	RADIOISOTOPE	13	0	156	0	8,564	56.00
57.00	05700	CT SCAN	18	0	527	0	66,665	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26	0	197	0	10,548	58.00
60.00	06000	LABORATORY	88	0	923	0	0	60.00
66.00	06600	PHYSICAL THERAPY	73	0	541	0	4,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	6	0	120	0	128	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	69	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	172	0	4,438	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	87,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	87	0	750	0	48,458	76.00
76.97	07697	CARDIAC REHABILITATION	31	0	34	0	238	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	66	0	218	2,435	6,253	90.00
91.00	09100	EMERGENCY	300	0	1,716	25,084	170,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,829	2,240	10,346	76,087	690,910	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	84	0	161	0	1,642	192.00
192.02	19202	MOB	392	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	791,922	820,472	241,484	1,773,263	1,386,045	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	343.567028	366.282143	22.983154	23.305729	2.001359	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	93,245	74,454	33,252	84,161	250,127	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	40.453362	33.238393	3.164747	1.106115	0.361167	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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:40 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB				1.02
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 - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - TLMOB				7.02
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	2,723,544			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	6,886	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,770	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,553	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33	0		55.00
56.00	05600	RADIOISOTOPE	210	0		56.00
57.00	05700	CT SCAN	147	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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	5	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	389,094	0		73.00
73.01	07301	ONCOLOGY DRUGS	2,306,631	0		73.01
76.00	03160	CARDIOPULMONARY	6	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4,197	0		90.00
91.00	09100	EMERGENCY	10,001	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,723,544	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,536,377	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.564109	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	127,775	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.046915	0.000000		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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:40 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	6,442,674		6,442,674	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,765,797		2,765,797	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,086,150		1,086,150	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	248,695		248,695	0	0	55.00
56.00	05600	RADIOISOTOPE	291,512		291,512	0	0	56.00
57.00	05700	CT SCAN	850,515		850,515	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	362,633		362,633	0	0	58.00
60.00	06000	LABORATORY	2,039,536		2,039,536	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,038,347	0	1,038,347	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,381	0	236,381	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	132,776	0	132,776	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	284,892		284,892	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	205,281		205,281	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,013		30,013	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	730,299		730,299	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	4,329,368		4,329,368	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,312,872		1,312,872	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	321,480		321,480	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	526,693		526,693	0	0	90.00
91.00	09100	EMERGENCY	5,448,662		5,448,662	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,500,303		1,500,303		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	30,184,879	0	30,184,879	0	0	200.00
201.00		Less Observation Beds	1,500,303		1,500,303		0	201.00
202.00		Total (see instructions)	28,684,576	0	28,684,576	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,493,934		4,493,934			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,341	7,183,604	7,195,945	0.384355	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,977	5,474,609	5,546,586	0.195823	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	25,465	926,395	951,860	0.261273	0.000000	55.00
56.00	05600	RADIOISOTOPE	84,968	2,319,348	2,404,316	0.121245	0.000000	56.00
57.00	05700	CT SCAN	193,832	4,489,425	4,683,257	0.181608	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	78,639	1,437,173	1,515,812	0.239233	0.000000	58.00
60.00	06000	LABORATORY	806,725	5,406,799	6,213,524	0.328241	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	402,110	1,576,380	1,978,490	0.524818	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,798	172,687	352,485	0.670613	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,743	157,257	182,000	0.729538	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,524,421	1,524,421	0.186885	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,214	601,487	609,701	0.336691	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	96,380	96,380	0.311403	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,372,063	2,899,030	4,271,093	0.170986	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	11,908,888	11,908,888	0.363541	0.000000	73.01
76.00	03160	CARDIOPULMONARY	781,317	3,184,750	3,966,067	0.331026	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	73	383,778	383,851	0.837512	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,289,168	2,289,168	0.230081	0.000000	90.00
91.00	09100	EMERGENCY	538,363	25,179,683	25,718,046	0.211861	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,150	4,930,117	4,954,267	0.302830	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	9,098,712	82,141,379	91,240,091			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,098,712	82,141,379	91,240,091			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:40 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY DRUGS	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			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:40 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	6,442,674		6,442,674	0	6,442,674	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,765,797		2,765,797	0	2,765,797	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,086,150		1,086,150	0	1,086,150	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	248,695		248,695	0	248,695	55.00
56.00	05600	RADIOISOTOPE	291,512		291,512	0	291,512	56.00
57.00	05700	CT SCAN	850,515		850,515	0	850,515	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	362,633		362,633	0	362,633	58.00
60.00	06000	LABORATORY	2,039,536		2,039,536	0	2,039,536	60.00
66.00	06600	PHYSICAL THERAPY	1,038,347	0	1,038,347	0	1,038,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,381	0	236,381	0	236,381	67.00
68.00	06800	SPEECH PATHOLOGY	132,776	0	132,776	0	132,776	68.00
69.00	06900	ELECTROCARDIOLOGY	284,892		284,892	0	284,892	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	205,281		205,281	0	205,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,013		30,013	0	30,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	730,299		730,299	0	730,299	73.00
73.01	07301	ONCOLOGY DRUGS	4,329,368		4,329,368	0	4,329,368	73.01
76.00	03160	CARDIOPULMONARY	1,312,872		1,312,872	0	1,312,872	76.00
76.97	07697	CARDIAC REHABILITATION	321,480		321,480	0	321,480	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	526,693		526,693	0	526,693	90.00
91.00	09100	EMERGENCY	5,448,662		5,448,662	0	5,448,662	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,500,303		1,500,303		1,500,303	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	30,184,879	0	30,184,879	0	30,184,879	200.00
201.00		Less Observation Beds	1,500,303		1,500,303		1,500,303	201.00
202.00		Total (see instructions)	28,684,576	0	28,684,576	0	28,684,576	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:40 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	4,493,934		4,493,934			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,341	7,183,604	7,195,945	0.384355	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,977	5,474,609	5,546,586	0.195823	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	25,465	926,395	951,860	0.261273	0.000000	55.00
56.00	05600	RADIOISOTOPE	84,968	2,319,348	2,404,316	0.121245	0.000000	56.00
57.00	05700	CT SCAN	193,832	4,489,425	4,683,257	0.181608	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	78,639	1,437,173	1,515,812	0.239233	0.000000	58.00
60.00	06000	LABORATORY	806,725	5,406,799	6,213,524	0.328241	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	402,110	1,576,380	1,978,490	0.524818	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,798	172,687	352,485	0.670613	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,743	157,257	182,000	0.729538	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,524,421	1,524,421	0.186885	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,214	601,487	609,701	0.336691	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	96,380	96,380	0.311403	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,372,063	2,899,030	4,271,093	0.170986	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	11,908,888	11,908,888	0.363541	0.000000	73.01
76.00	03160	CARDIOPULMONARY	781,317	3,184,750	3,966,067	0.331026	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	73	383,778	383,851	0.837512	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,289,168	2,289,168	0.230081	0.000000	90.00
91.00	09100	EMERGENCY	538,363	25,179,683	25,718,046	0.211861	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,150	4,930,117	4,954,267	0.302830	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	9,098,712	82,141,379	91,240,091			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,098,712	82,141,379	91,240,091			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:40 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY DRUGS	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			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 8:40 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	526,295	7,195,945	0.073138	12,341	903	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,353	5,546,586	0.032336	29,642	959	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	36,914	951,860	0.038781	13,541	525	55.00
56.00	05600	RADIOISOTOPE	30,288	2,404,316	0.012597	56,542	712	56.00
57.00	05700	CT SCAN	67,108	4,683,257	0.014329	54,628	783	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53,160	1,515,812	0.035070	50,892	1,785	58.00
60.00	06000	LABORATORY	178,248	6,213,524	0.028687	390,490	11,202	60.00
66.00	06600	PHYSICAL THERAPY	158,997	1,978,490	0.080363	135,430	10,884	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,069	352,485	0.042751	54,919	2,348	67.00
68.00	06800	SPEECH PATHOLOGY	7,413	182,000	0.040731	15,347	625	68.00
69.00	06900	ELECTROCARDIOLOGY	38,976	1,524,421	0.025568	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,067	609,701	0.052595	4,444	234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,445	96,380	0.035744	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,748	4,271,093	0.006028	676,914	4,080	73.00
73.01	07301	ONCOLOGY DRUGS	152,638	11,908,888	0.012817	0	0	73.01
76.00	03160	CARDIOPULMONARY	105,477	3,966,067	0.026595	448,204	11,920	76.00
76.97	07697	CARDIAC REHABILITATION	29,745	383,851	0.077491	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	89,921	2,289,168	0.039281	0	0	90.00
91.00	09100	EMERGENCY	478,698	25,718,046	0.018613	24,334	453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	210,830	4,954,267	0.042555	2,475	105	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
200.00		Total (lines 50 through 199)	2,420,390	86,746,157		1,970,143	47,518	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:40 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:40 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	7,195,945	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,546,586	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	951,860	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,404,316	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	4,683,257	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,515,812	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	6,213,524	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,978,490	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	352,485	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	182,000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,524,421	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	609,701	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	96,380	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,271,093	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	11,908,888	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	3,966,067	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	383,851	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,289,168	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,718,046	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,954,267	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	86,746,157		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:40 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	12,341	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	29,642	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	13,541	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	56,542	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	54,628	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	50,892	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	390,490	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	135,430	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	54,919	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,347	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,444	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	676,914	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	448,204	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	24,334	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,475	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		1,970,143	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:40 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	0.384355	0	2,459,352	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195823	0	1,444,231	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.261273	0	383,506	0	0	55.00
56.00	05600	RADIOISOTOPE	0.121245	0	963,978	0	0	56.00
57.00	05700	CT SCAN	0.181608	0	1,708,031	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.239233	0	575,734	0	0	58.00
60.00	06000	LABORATORY	0.328241	0	2,133,389	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.524818	0	633,812	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.670613	0	64,040	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.729538	0	30,501	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186885	0	496,101	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336691	0	252,048	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311403	0	26,866	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170986	0	737,320	1,327	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.363541	0	5,824,621	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.331026	0	1,354,898	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.837512	0	168,041	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.230081	0	1,405,171	0	0	90.00
91.00	09100	EMERGENCY	0.211861	0	6,661,866	2,210	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302830	0	2,063,985	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	29,387,491	3,537	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	29,387,491	3,537	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:40 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	945,264	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	282,814	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	100,200	0	55.00
56.00	05600	RADIOISOTOPE	116,878	0	56.00
57.00	05700	CT SCAN	310,192	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	137,735	0	58.00
60.00	06000	LABORATORY	700,266	0	60.00
66.00	06600	PHYSICAL THERAPY	332,636	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,946	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,252	0	68.00
69.00	06900	ELECTROCARDIOLOGY	92,714	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,862	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,366	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	126,071	227	73.00
73.01	07301	ONCOLOGY DRUGS	2,117,489	0	73.01
76.00	03160	CARDIOPULMONARY	448,506	0	76.00
76.97	07697	CARDIAC REHABILITATION	140,736	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	323,303	0	90.00
91.00	09100	EMERGENCY	1,411,390	468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	625,037	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
200.00		Subtotal (see instructions)	8,369,657	695	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	8,369,657	695	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 8:40 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	0.384355	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195823	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.261273	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.121245	0	0	0	0	56.00
57.00	05700	CT SCAN	0.181608	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.239233	0	0	0	0	58.00
60.00	06000	LABORATORY	0.328241	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.524818	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.670613	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.729538	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186885	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336691	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311403	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170986	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.363541	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.331026	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.837512	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.230081	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.211861	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302830	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
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: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:40 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY DRUGS	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				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:40 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	0.384355	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195823	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.261273	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.121245	0	0	0	0	56.00
57.00	05700	CT SCAN	0.181608	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.239233	0	0	0	0	58.00
60.00	06000	LABORATORY	0.328241	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.524818	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.670613	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.729538	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186885	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336691	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311403	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170986	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.363541	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.331026	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.837512	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.230081	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.211861	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302830	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:40 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	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY DRUGS	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				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:40 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)	2,811	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,283	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,712	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	152	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	376	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)	1,014	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)	152	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)	6,442,674	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)	44,706	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)	444,086	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,998,588	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)	5,998,588	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)	2,627.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,664,285	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)	2,664,285	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:40 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)	561,824	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,226,109	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)	399,380	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)	399,380	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)	571	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,627.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,500,303	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:40 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	905,359	6,442,674	0.140525	1,500,303	210,830	90.00
91.00	Nursing School cost	0	6,442,674	0.000000	1,500,303	0	91.00
92.00	Allied health cost	0	6,442,674	0.000000	1,500,303	0	92.00
93.00	All other Medical Education	0	6,442,674	0.000000	1,500,303	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:40 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)	2,811	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,283	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,712	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	152	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	376	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)	12	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)	6,442,674	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)	44,706	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)	444,086	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,998,588	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)	5,998,588	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)	2,627.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	31,530	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)	31,530	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:40 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)	14,922	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	46,452	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)	571	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,627.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,500,303	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:40 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	905,359	6,442,674	0.140525	1,500,303	210,830	90.00
91.00	Nursing School cost	0	6,442,674	0.000000	1,500,303	0	91.00
92.00	Allied health cost	0	6,442,674	0.000000	1,500,303	0	92.00
93.00	All other Medical Education	0	6,442,674	0.000000	1,500,303	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:40 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		2,213,683		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.384355	12,341	4,743	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195823	29,642	5,805	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.261273	13,541	3,538	55.00
56.00	05600	RADIOISOTOPE	0.121245	56,542	6,855	56.00
57.00	05700	CT SCAN	0.181608	54,628	9,921	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.239233	50,892	12,175	58.00
60.00	06000	LABORATORY	0.328241	390,490	128,175	60.00
66.00	06600	PHYSICAL THERAPY	0.524818	135,430	71,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.670613	54,919	36,829	67.00
68.00	06800	SPEECH PATHOLOGY	0.729538	15,347	11,196	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186885	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336691	4,444	1,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311403	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170986	676,914	115,743	73.00
73.01	07301	ONCOLOGY DRUGS	0.363541	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.331026	448,204	148,367	76.00
76.97	07697	CARDIAC REHABILITATION	0.837512	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.230081	0	0	90.00
91.00	09100	EMERGENCY	0.211861	24,334	5,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302830	2,475	750	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,970,143	561,824	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,970,143		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:40 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	0.384355	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195823	2,266	444	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.261273	4,151	1,085	55.00
56.00	05600	RADIOISOTOPE	0.121245	0	0	56.00
57.00	05700	CT SCAN	0.181608	744	135	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.239233	0	0	58.00
60.00	06000	LABORATORY	0.328241	18,347	6,022	60.00
66.00	06600	PHYSICAL THERAPY	0.524818	53,730	28,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.670613	25,711	17,242	67.00
68.00	06800	SPEECH PATHOLOGY	0.729538	3,789	2,764	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186885	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336691	78	26	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311403	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170986	29,259	5,003	73.00
73.01	07301	ONCOLOGY DRUGS	0.363541	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.331026	15,091	4,996	76.00
76.97	07697	CARDIAC REHABILITATION	0.837512	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.230081	0	0	90.00
91.00	09100	EMERGENCY	0.211861	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302830	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		153,166	65,915	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)		153,166		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:40 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		25,993		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.384355	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195823	1,974	387	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.261273	0	0	55.00
56.00	05600	RADIOISOTOPE	0.121245	0	0	56.00
57.00	05700	CT SCAN	0.181608	1,643	298	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.239233	0	0	58.00
60.00	06000	LABORATORY	0.328241	8,033	2,637	60.00
66.00	06600	PHYSICAL THERAPY	0.524818	976	512	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.670613	455	305	67.00
68.00	06800	SPEECH PATHOLOGY	0.729538	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186885	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336691	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311403	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170986	10,146	1,735	73.00
73.01	07301	ONCOLOGY DRUGS	0.363541	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.331026	2,605	862	76.00
76.97	07697	CARDIAC REHABILITATION	0.837512	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.230081	0	0	90.00
91.00	09100	EMERGENCY	0.211861	18,807	3,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302830	13,875	4,202	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,514	14,922	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		58,514		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 8:40 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,370,352	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)	8,370,352	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)	8,454,056	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	74,254	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,374,089	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)	3,005,713	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)	3,005,713	30.00
31.00	Primary payer payments	1,365	31.00
32.00	Subtotal (line 30 minus line 31)	3,004,348	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,003,196	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	652,077	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	647,447	36.00
37.00	Subtotal (see instructions)	3,656,425	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,656,425	40.00
40.01	Sequestration adjustment (see instructions)	73,129	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	3,875,805	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)	-292,509	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	494,231	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: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 6/29/2020 8:40 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		2,425,652		3,875,805	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/23/2019	116,100		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)		116,100		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,541,752		3,875,805	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		363,310		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		292,509	6.02
7.00	Total Medicare program liability (see instructions)		2,905,062		3,583,296	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: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/29/2020 8:40 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		390,188		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/23/2019	46,900		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)		46,900		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)		437,088		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		22,563		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		459,651		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: 15-1312	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/29/2020 8:40 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: 15-1312 Component CCN: 15-Z312	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2 Date/Time Prepared: 6/29/2020 8:40 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)	403,374	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)	66,574	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	152	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)	469,948	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	469,948	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)	469,948	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,023	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	468,925	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)	165	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	107	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	469,032	0	19.00
19.01	Sequestration adjustment (see instructions)	9,381	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	437,088	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)	22,563	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	27,625	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: 15-1312	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 8:40 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,226,109	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)	3,226,109	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,258,370	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)	3,258,370	19.00
20.00	Deductibles (exclude professional component)	312,308	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,946,062	22.00
23.00	Coinsurance	341	23.00
24.00	Subtotal (line 22 minus line 23)	2,945,721	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,659	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,628	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,010	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,964,349	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)	2,964,349	30.00
30.01	Sequestration adjustment (see instructions)	59,287	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,541,752	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)	363,310	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	191,495	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/29/2020 8:40 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	26,318,590	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,737,685	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	232,295	0	0	0	7.00
8.00	Prepaid expenses	252,273	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)	28,540,843	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	972,779	0	0	0	12.00
13.00	Land improvements	122,178	0	0	0	13.00
14.00	Accumulated depreciation	-96,584	0	0	0	14.00
15.00	Buildings	30,277,094	0	0	0	15.00
16.00	Accumulated depreciation	-6,659,791	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,524,008	0	0	0	23.00
24.00	Accumulated depreciation	-6,548,559	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)	28,591,125	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	158,803	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	30,175	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	188,978	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	57,320,946	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,868,419	0	0	0	37.00
38.00	Salaries, wages, and fees payable	860,766	0	0	0	38.00
39.00	Payroll taxes payable	44,640	0	0	0	39.00
40.00	Notes and loans payable (short term)	650,000	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	4,921,253	0	0	0	43.00
44.00	Other current liabilities	10,750	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,355,828	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	19,665,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	39,388	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,704,388	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,060,216	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,260,730				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)	29,260,730	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	57,320,946	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/29/2020 8:40 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,106,675		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,065,406				2.00
3.00	Total (sum of line 1 and line 2)		29,172,081		0		3.00
4.00	NET INTERCOMPANY TRANSACTIONS	88,647		0		0	4.00
5.00	ROUNDING	2		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)		88,649		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,260,730		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,260,730		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	NET INTERCOMPANY TRANSACTIONS		0			4.00
5.00	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/29/2020 8:40 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,024,013		4,024,013	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	469,921		469,921	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)	4,493,934		4,493,934	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)	4,493,934		4,493,934	17.00
18.00	Ancillary services	4,042,265	49,742,411	53,784,676	18.00
19.00	Outpatient services	562,513	32,398,968	32,961,481	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				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	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,098,712	82,141,379	91,240,091	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,037,026		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)		30,037,026		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1312	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 6/29/2020 8:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	91,240,091	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,681,382	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,558,709	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,037,026	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-478,317	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,543,723	24.00
25.00	Total other income (sum of lines 6-24)	1,543,723	25.00
26.00	Total (line 5 plus line 25)	1,065,406	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,065,406	29.00