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: 15-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/31/2020 7:53 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/31/2020 Time: 7:53 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by INDIANA ORTHOPAEDIC HOSPITAL,LLC (15-0160) 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.

[ ] 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)_____
Officer or Administrator of Provider(s)

_____
Title

_____
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	1	50,694	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
8.00	NURSING FACILITY	0				0	8.00
200.00	Total	0	1	50,694	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 7:53 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8450 NORTHWEST BOULEVARD	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46278	County: MARION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	INDIANA ORTHOPAEDIC HOSPITAL,LLC	150160	26900	1	03/23/2005	N	P	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	5		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.	2	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2020 7:53 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2020 7:53 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 7:53 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 7:53 am

		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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?	N		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)			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)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			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:	279,741	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.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 7:53 am

		1.00	2.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0995	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA ORTHOPAEDIC HOSPITAL	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 8450 NORTHWEST BOULEVARD	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46278	143.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 7:53 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2020 7:53 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/09/2020	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/24/2020	Y	04/24/2020	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)	N		N		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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 8/31/2020 7:53 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.	N	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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4182	KBEJARANO@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 8/31/2020 7:53 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.	SENIOR MANAGING CONSULTANT		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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2020 7:53 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	38	13,870	0.00	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)		38	13,870	0.00	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)		38	13,870	0.00	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	45.00	0	0		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		38				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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2020 7:53 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)	1,872	35	4,900			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,872	35	4,900			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)	1,872	35	4,900	0.00	316.87	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	316.87	27.00
28.00	Observation Bed Days		7	1,400			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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2020 7:53 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	1,188	18	3,270	1.00
2.00	HMO and other (see instructions)			0	0		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	1,188	18	3,270	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	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 8/31/2020 7:53 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	22,296,780	0	22,296,780	659,099.94	33.83	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,260,209	0	1,260,209	26,606.39	47.36	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,432,426	0	6,432,426	134,412.32	47.86	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,275,813	0	6,275,813			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,753,746	0	1,753,746			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 8/31/2020 7:53 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,258,660	0	2,258,660	89,936.43	25.11	27.00
28.00	Administrative & General under contract (see inst.)		191,091	0	191,091	1,040.42	183.67	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,002,493	0	1,002,493	41,860.00	23.95	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		910,945	0	910,945	40,591.00	22.44	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	230,623	0	230,623	10,403.51	22.17	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 8/31/2020 7:53 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		24,401,309	0	24,401,309	742,591.36	32.86	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,401,309	0	24,401,309	742,591.36	32.86	3.00
4.00	Subtotal other wages & related costs (see inst.)		7,692,635	0	7,692,635	161,018.71	47.77	4.00
5.00	Subtotal wage-related costs (see inst.)		8,029,559	0	8,029,559	0.00	32.91	5.00
6.00	Total (sum of lines 3 thru 5)		40,123,503	0	40,123,503	903,610.07	44.40	6.00
7.00	Total overhead cost (see instructions)		4,593,812	0	4,593,812	183,831.36	24.99	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part IV Date/Time Prepared: 8/31/2020 7:53 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,157,759	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,251,435	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	30,165	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	255,922	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	129,748	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,106,398	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	55,116	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	43,016	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,029,559	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part V Date/Time Prepared: 8/31/2020 7:53 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,260,209	8,029,559	1.00
2.00	Hospital	1,260,209	8,029,559	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/31/2020 7:53 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)	0.254647	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	883,232	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?	N	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	3,104,156	6.00
7.00	Medicaid cost (line 1 times line 6)	790,464	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)	0	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)	0	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)	517,060	869,279	1,386,339	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	131,668	869,279	1,000,947	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	131,668	869,279	1,000,947	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)	3,656,501	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	51,732	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	79,588	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,576,913	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	938,706	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,939,653	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,939,653	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/31/2020 7:53 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		11,177,472	11,177,472	64,211	11,241,683	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,277,096	6,277,096	0	6,277,096	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,258,660	24,399,217	26,657,877	139,216	26,797,093	5.00
7.00	00700	OPERATION OF PLANT	0	243,301	243,301	56,372	299,673	7.00
10.00	01000	DIETARY	0	1,572,788	1,572,788	-1,364,442	208,346	10.00
11.00	01100	CAFETERIA	0	0	0	1,364,442	1,364,442	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	230,623	71,763	302,386	0	302,386	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,044,734	1,016,349	5,061,083	0	5,061,083	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,866,195	8,433,872	19,300,067	-534,084	18,765,983	50.00
53.00	05300	ANESTHESIOLOGY	66,546	370,349	436,895	0	436,895	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	793,696	563,578	1,357,274	534,084	1,891,358	54.00
60.00	06000	LABORATORY	0	1,088,175	1,088,175	0	1,088,175	60.00
66.00	06600	PHYSICAL THERAPY	3,716,436	963,736	4,680,172	0	4,680,172	66.00
67.00	06700	OCCUPATIONAL THERAPY	319,890	24,485	344,375	0	344,375	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	27,602,321	27,602,321	-22,330,326	5,271,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,330,326	22,330,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,448,122	3,448,122	0	3,448,122	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,296,780	87,252,624	109,549,404	259,799	109,809,203	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	400,094	400,094	0	400,094	194.00
194.01	07951	NNS	0	432,645	432,645	-259,799	172,846	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	22,296,780	88,085,363	110,382,143	0	110,382,143	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/31/2020 7:53 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	86,203	11,327,886		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,277,096		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,767,821	22,029,272		5.00
7.00	00700	OPERATION OF PLANT	-243,301	56,372		7.00
10.00	01000	DIETARY	-972	207,374		10.00
11.00	01100	CAFETERIA	-392,108	972,334		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,551	294,835		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,061,083		30.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-469	18,765,514		50.00
53.00	05300	ANESTHESIOLOGY	0	436,895		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,891,358		54.00
60.00	06000	LABORATORY	0	1,088,175		60.00
66.00	06600	PHYSICAL THERAPY	-16,207	4,663,965		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	344,375		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,271,995		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,330,326		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,448,122		73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,342,226	104,466,977		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	400,094		194.00
194.01	07951	NNS	0	172,846		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,342,226	105,039,917		200.00

RECLASSIFICATIONS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/31/2020 7:53 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	0	1,364,442		1.00
	0		0	1,364,442		
	B - BUILDING EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	64,211		1.00
	0		0	64,211		
	C - A&G EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	139,216		1.00
	0		0	139,216		
	D - PLANT OPERATIONS EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	56,372		1.00
	0		0	56,372		
	E - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	22,330,326		1.00
	0		0	22,330,326		
	F - RADIOLOGY RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	534,084	0		1.00
	0		534,084	0		
500.00	Grand Total: Increases		534,084	23,954,567		500.00

RECLASSIFICATIONS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/31/2020 7:53 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	0	1,364,442	0		1.00
	0		0	1,364,442			
	B - BUILDING EXPENSE						
1.00	NNS	194.01	0	64,211	9		1.00
	0		0	64,211			
	C - A&G EXPENSE						
1.00	NNS	194.01	0	139,216	0		1.00
	0		0	139,216			
	D - PLANT OPERATIONS EXPENSE						
1.00	NNS	194.01	0	56,372	0		1.00
	0		0	56,372			
	E - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	22,330,326	0		1.00
	0		0	22,330,326			
	F - RADIOLOGY RECLASS						
1.00	OPERATING ROOM	50.00	534,084	0	0		1.00
	0		534,084	0			
500.00	Grand Total: Decreases		534,084	23,954,567			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 8/31/2020 7:53 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	778,901	0	0	0	0	1.00
2.00	Land Improvements	846,675	337,227	0	337,227	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	32,708,484	3,535,177	0	3,535,177	2,495,801	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,334,060	3,872,404	0	3,872,404	2,495,801	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,334,060	3,872,404	0	3,872,404	2,495,801	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	778,901	0	1.00
2.00	Land Improvements	1,183,902	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	33,747,860	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,710,663	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,710,663	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II Date/Time Prepared: 8/31/2020 7:53 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	2,724,754	8,119,719	0	106,815	226,184	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,724,754	8,119,719	0	106,815	226,184	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	11,177,472		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	11,177,472		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 8/31/2020 7:53 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,962,803	0	1,962,803	0.054964	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	33,747,860	0	33,747,860	0.945036	0	2.00
3.00	Total (sum of lines 1-2)	35,710,663	0	35,710,663	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,875,168	8,119,719	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,875,168	8,119,719	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	106,815	226,184	0	11,327,886	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	106,815	226,184	0	11,327,886	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/31/2020 7:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-606	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,025,296			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-392,108	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	B	-7,551	MEDICAL RECORDS & LIBRARY	16.00	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/31/2020 7:53 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSE OFFSET	A	-44,562	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	APPLICATION FEE REVENUE	B	-19,210	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	REBATES	B	-73,147	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	FINES AND PENALTIES	B	-450	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	GIFT AND DONATION EXPENSE OFFSET	A	-1,613	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.06	GIFT AND DONATION EXPENSE OFFSET	A	-469	OPERATING ROOM	50.00	0	33.06
33.11	PROVIDER TAX	A	-2,516,734	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MARKETING EXPENSE OFFSET	A	-16,207	PHYSICAL THERAPY	66.00	0	33.12
33.14	MARKETING EXPENSE OFFSET	A	-972	DIETARY	10.00	0	33.14
33.15	PATIENT PHONE SERVICE	A	-243,301	OPERATION OF PLANT	7.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,342,226				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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 8/31/2020 7:53 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	5.00	ADMINISTRATIVE & GENERAL	OI CHARGEBACKS	4,673,513	4,673,513	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	OIE SERVICES	8,099,429	10,211,534	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	OIE CRC	86,809	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,859,751	14,885,047	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	C	OI PRACTICE	0.00		0.00	6.00
7.00	C	NNS	100.00		0.00	7.00
8.00	C	OI ENTERPRISES	0.00	HOME OFFICE	100.00	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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 8/31/2020 7:53 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	0	0		1.00
2.00	-2,112,105	0		2.00
3.00	86,809	9		3.00
4.00	0	0		4.00
5.00	-2,025,296			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	HOME OFFICE		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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,327,886	11,327,886				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,277,096	0	0	6,277,096		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,029,272	402,260	0	635,869	23,067,401	5.00
7.00	00700	OPERATION OF PLANT	56,372	2,741,066	0	0	2,797,438	7.00
10.00	01000	DIETARY	207,374	123,299	0	0	330,673	10.00
11.00	01100	CAFETERIA	972,334	204,010	0	0	1,176,344	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	164,593	0	0	164,593	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	294,835	0	0	64,926	359,761	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,061,083	2,229,358	0	1,138,694	8,429,135	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,765,514	4,064,612	0	2,908,743	25,738,869	50.00
53.00	05300	ANESTHESIOLOGY	436,895	0	0	18,734	455,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,891,358	522,000	0	373,803	2,787,161	54.00
60.00	06000	LABORATORY	1,088,175	100,646	0	0	1,188,821	60.00
66.00	06600	PHYSICAL THERAPY	4,663,965	692,224	0	1,046,270	6,402,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	344,375	0	0	90,057	434,432	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,271,995	0	0	0	5,271,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,330,326	0	0	0	22,330,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,448,122	83,818	0	0	3,531,940	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,466,977	11,327,886	0	6,277,096	104,466,977	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	400,094	0	0	0	400,094	194.00
194.01	07951	NNS	172,846	0	0	0	172,846	194.01
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)	105,039,917	11,327,886	0	6,277,096	105,039,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
			5.00	7.00	10.00	11.00	12.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,067,401					5.00
7.00	00700	OPERATION OF PLANT	787,210	3,584,648				7.00
10.00	01000	DIETARY	93,053	54,002	477,728			10.00
11.00	01100	CAFETERIA	331,028	89,352	414,444	2,011,168		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,317	72,088	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,238	0	0	36,759	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,371,992	976,407	63,284	409,414	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,243,028	1,780,206	0	1,040,801	0	50.00
53.00	05300	ANESTHESIOLOGY	128,216	0	0	7,929	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	784,318	228,624	0	160,409	0	54.00
60.00	06000	LABORATORY	334,539	44,081	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,801,678	303,178	0	330,669	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,251	0	0	25,187	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,483,560	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,283,843	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	993,902	36,710	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,906,173	3,584,648	477,728	2,011,168	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	112,588	0	0	0	0	194.00
194.01	07951	NNS	48,640	0	0	0	0	194.01
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)	23,067,401	3,584,648	477,728	2,011,168	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	282,998				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	497,758			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	13,194	12,263,426	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	285,282	36,088,186	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	16,131	607,905	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	39,681	4,000,193	0	54.00
60.00	06000	LABORATORY	0	0	5,149	1,572,590	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	31,955	8,869,939	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,580	584,450	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	54,054	16,371	6,825,980	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	228,944	69,150	28,912,263	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,265	4,580,817	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	282,998	497,758	104,305,749	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	512,682	0	194.00
194.01	07951	NNS	0	0	0	221,486	0	194.01
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)	0	282,998	497,758	105,039,917	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	12,263,426		30.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	36,088,186		50.00
53.00	05300	ANESTHESIOLOGY	607,905		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,000,193		54.00
60.00	06000	LABORATORY	1,572,590		60.00
66.00	06600	PHYSICAL THERAPY	8,869,939		66.00
67.00	06700	OCCUPATIONAL THERAPY	584,450		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,825,980		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,912,263		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,580,817		73.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,305,749		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	512,682		194.00
194.01	07951	NNS	221,486		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	105,039,917		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	402,260	0	402,260	0	5.00
7.00	00700	OPERATION OF PLANT	0	2,741,066	0	2,741,066	0	7.00
10.00	01000	DIETARY	0	123,299	0	123,299	0	10.00
11.00	01100	CAFETERIA	0	204,010	0	204,010	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	164,593	0	164,593	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,229,358	0	2,229,358	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,064,612	0	4,064,612	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	522,000	0	522,000	0	54.00
60.00	06000	LABORATORY	0	100,646	0	100,646	0	60.00
66.00	06600	PHYSICAL THERAPY	0	692,224	0	692,224	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	83,818	0	83,818	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,327,886	0	11,327,886	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	NNS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	11,327,886	0	11,327,886	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
			5.00	7.00	10.00	11.00	12.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	402,260					5.00
7.00	00700	OPERATION OF PLANT	13,727	2,754,793				7.00
10.00	01000	DIETARY	1,623	41,501	166,423			10.00
11.00	01100	CAFETERIA	5,772	68,667	144,377	422,826		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	808	55,400	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,765	0	0	7,728	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,362	750,366	22,046	86,075	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	126,320	1,368,082	0	218,817	0	50.00
53.00	05300	ANESTHESIOLOGY	2,236	0	0	1,667	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,677	175,697	0	33,724	0	54.00
60.00	06000	LABORATORY	5,834	33,876	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	31,417	232,992	0	69,520	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,132	0	0	5,295	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,870	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	109,575	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,331	28,212	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	399,449	2,754,793	166,423	422,826	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	1,963	0	0	0	0	194.00
194.01	07951	NNS	848	0	0	0	0	194.01
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)	402,260	2,754,793	166,423	422,826	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	220,801				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	9,493			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	250	3,129,457	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	5,471	5,783,302	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	305	4,208	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	751	745,849	0	54.00
60.00	06000	LABORATORY	0	0	97	140,453	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	605	1,026,758	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	49	7,476	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	42,171	310	68,351	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	178,630	1,309	289,514	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	346	129,707	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	220,801	9,493	11,325,075	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	1,963	0	194.00
194.01	07951	NNS	0	0	0	848	0	194.01
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)	0	220,801	9,493	11,327,886	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,129,457		30.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	5,783,302		50.00
53.00	05300	ANESTHESIOLOGY	4,208		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	745,849		54.00
60.00	06000	LABORATORY	140,453		60.00
66.00	06600	PHYSICAL THERAPY	1,026,758		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,476		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,351		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	289,514		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,707		73.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,325,075		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	1,963		194.00
194.01	07951	NNS	848		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	11,327,886		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	175,018					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	22,296,780			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,215	0	2,258,660	-23,067,401	81,972,516	5.00
7.00	00700	OPERATION OF PLANT	42,350	0	0	0	2,797,438	7.00
10.00	01000	DIETARY	1,905	0	0	0	330,673	10.00
11.00	01100	CAFETERIA	3,152	0	0	0	1,176,344	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,543	0	0	0	164,593	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	230,623	0	359,761	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,444	0	4,044,734	0	8,429,135	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,799	0	10,332,111	0	25,738,869	50.00
53.00	05300	ANESTHESIOLOGY	0	0	66,546	0	455,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,065	0	1,327,780	0	2,787,161	54.00
60.00	06000	LABORATORY	1,555	0	0	0	1,188,821	60.00
66.00	06600	PHYSICAL THERAPY	10,695	0	3,716,436	0	6,402,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	319,890	0	434,432	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,271,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	22,330,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,295	0	0	0	3,531,940	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,018	0	22,296,780	-23,067,401	81,399,576	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	0	400,094	194.00
194.01	07951	NNS	0	0	0	0	172,846	194.01
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)	11,327,886	0	6,277,096		23,067,401	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	64.724120	0.000000	0.281525		0.281404	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		402,260	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.004907	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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			7.00	10.00	11.00	12.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	126,453					7.00
10.00	01000	DIETARY	1,905	143,407				10.00
11.00	01100	CAFETERIA	3,152	124,410	569,164			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,543	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	10,403	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,444	18,997	115,865	0	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,799	0	294,548	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,244	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,065	0	45,396	0	0	54.00
60.00	06000	LABORATORY	1,555	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	10,695	0	93,580	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	7,128	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,295	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,453	143,407	569,164	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	NNS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,584,648	477,728	2,011,168	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.347671	3.331274	3.533547	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,754,793	166,423	422,826	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	21.785114	1.160494	0.742890	0.000000	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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/31/2020 7:53 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,602,321			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	409,609,404		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	10,859,529		30.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	234,731,598		50.00
53.00	05300	ANESTHESIOLOGY	0	13,276,539		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,658,990		54.00
60.00	06000	LABORATORY	0	4,238,187		60.00
66.00	06600	PHYSICAL THERAPY	0	26,300,731		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,123,234		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,271,995	13,474,010		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,330,326	56,913,281		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,033,305		73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,602,321	409,609,404		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0		194.00
194.01	07951	NNS	0	0		194.01
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)	282,998	497,758		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010253	0.001215		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	220,801	9,493		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007999	0.000023		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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,263,426		12,263,426	0	12,263,426	30.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,088,186		36,088,186	0	36,088,186	50.00
53.00	05300	ANESTHESIOLOGY	607,905		607,905	0	607,905	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,000,193		4,000,193	0	4,000,193	54.00
60.00	06000	LABORATORY	1,572,590		1,572,590	0	1,572,590	60.00
66.00	06600	PHYSICAL THERAPY	8,869,939	0	8,869,939	0	8,869,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	584,450	0	584,450	0	584,450	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,825,980		6,825,980	0	6,825,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,912,263		28,912,263	0	28,912,263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,580,817		4,580,817	0	4,580,817	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,725,212		2,725,212		2,725,212	92.00
200.00		Subtotal (see instructions)	107,030,961	0	107,030,961	0	107,030,961	200.00
201.00		Less Observation Beds	2,725,212		2,725,212		2,725,212	201.00
202.00		Total (see instructions)	104,305,749	0	104,305,749	0	104,305,749	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		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	8,396,410		8,396,410			30.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	88,988,276	145,743,322	234,731,598	0.153742	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	3,282,228	9,994,311	13,276,539	0.045788	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	600,522	32,058,468	32,658,990	0.122484	0.000000	54.00
60.00	06000	LABORATORY	1,777,905	2,460,282	4,238,187	0.371053	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	3,051,936	23,248,795	26,300,731	0.337251	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,503	2,013,731	2,123,234	0.275264	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,107,997	8,366,013	13,474,010	0.506603	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,575,825	35,337,456	56,913,281	0.508006	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,236,841	9,796,464	15,033,305	0.304711	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	90,887	2,372,232	2,463,119	1.106407	0.000000	92.00
200.00		Subtotal (see instructions)	138,218,330	271,391,074	409,609,404			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	138,218,330	271,391,074	409,609,404			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.153742	50.00
53.00	05300	ANESTHESIOLOGY	0.045788	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122484	54.00
60.00	06000	LABORATORY	0.371053	60.00
66.00	06600	PHYSICAL THERAPY	0.337251	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.275264	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.506603	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508006	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304711	73.00
		OUTPATIENT SERVICE COST CENTERS		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.106407	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/31/2020 7:53 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	12,263,426		12,263,426	0	12,263,426	30.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,088,186		36,088,186	0	36,088,186	50.00
53.00	05300	ANESTHESIOLOGY	607,905		607,905	0	607,905	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,000,193		4,000,193	0	4,000,193	54.00
60.00	06000	LABORATORY	1,572,590		1,572,590	0	1,572,590	60.00
66.00	06600	PHYSICAL THERAPY	8,869,939	0	8,869,939	0	8,869,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	584,450	0	584,450	0	584,450	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,825,980		6,825,980	0	6,825,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,912,263		28,912,263	0	28,912,263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,580,817		4,580,817	0	4,580,817	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,725,212		2,725,212		2,725,212	92.00
200.00		Subtotal (see instructions)	107,030,961	0	107,030,961	0	107,030,961	200.00
201.00		Less Observation Beds	2,725,212		2,725,212		2,725,212	201.00
202.00		Total (see instructions)	104,305,749	0	104,305,749	0	104,305,749	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/31/2020 7:53 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	8,396,410		8,396,410			30.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	88,988,276	145,743,322	234,731,598	0.153742	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	3,282,228	9,994,311	13,276,539	0.045788	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	600,522	32,058,468	32,658,990	0.122484	0.000000	54.00
60.00	06000	LABORATORY	1,777,905	2,460,282	4,238,187	0.371053	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	3,051,936	23,248,795	26,300,731	0.337251	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,503	2,013,731	2,123,234	0.275264	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,107,997	8,366,013	13,474,010	0.506603	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,575,825	35,337,456	56,913,281	0.508006	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,236,841	9,796,464	15,033,305	0.304711	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	90,887	2,372,232	2,463,119	1.106407	0.000000	92.00
200.00		Subtotal (see instructions)	138,218,330	271,391,074	409,609,404			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	138,218,330	271,391,074	409,609,404			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/31/2020 7:53 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
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,129,457	0	3,129,457	6,300	496.74	30.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	3,129,457		3,129,457	6,300		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,872	929,897	30.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	1,872	929,897	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,783,302	234,731,598	0.024638	27,072,996	667,024	50.00
53.00	05300	ANESTHESIOLOGY	4,208	13,276,539	0.000317	1,200,563	381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	745,849	32,658,990	0.022837	284,262	6,492	54.00
60.00	06000	LABORATORY	140,453	4,238,187	0.033140	692,617	22,953	60.00
66.00	06600	PHYSICAL THERAPY	1,026,758	26,300,731	0.039039	1,153,938	45,049	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,476	2,123,234	0.003521	35,710	126	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,351	13,474,010	0.005073	1,365,864	6,929	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	289,514	56,913,281	0.005087	14,272,655	72,605	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,707	15,033,305	0.008628	1,910,109	16,480	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	695,436	2,463,119	0.282340	90,887	25,661	92.00
200.00		Total (lines 50 through 199)	8,891,054	401,212,994		48,079,601	863,700	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,300	0.00	1,872	30.00
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00
200.00		Total (lines 30 through 199)		0	6,300		1,872	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	234,731,598	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,276,539	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,658,990	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,238,187	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,300,731	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,123,234	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,474,010	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	56,913,281	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,033,305	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,463,119	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	401,212,994		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	27,072,996	0	26,511,311	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,200,563	0	1,742,112	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	284,262	0	6,617,770	0	54.00
60.00	06000	LABORATORY	0.000000	692,617	0	179,248	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,153,938	0	81,210	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	35,710	0	24,730	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,365,864	0	972,779	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	14,272,655	0	2,081,283	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,910,109	0	1,630,596	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	90,887	0	306,784	0	92.00
200.00		Total (lines 50 through 199)		48,079,601	0	40,147,823	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		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	0.153742	26,511,311	0	0	4,075,902	50.00
53.00	05300	ANESTHESIOLOGY	0.045788	1,742,112	0	0	79,768	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122484	6,617,770	0	0	810,571	54.00
60.00	06000	LABORATORY	0.371053	179,248	0	0	66,511	60.00
66.00	06600	PHYSICAL THERAPY	0.337251	81,210	0	0	27,388	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.275264	24,730	0	0	6,807	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.506603	972,779	0	0	492,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508006	2,081,283	0	0	1,057,304	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304711	1,630,596	0	0	496,861	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.106407	306,784	0	0	339,428	92.00
200.00		Subtotal (see instructions)		40,147,823	0	0	7,453,353	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		40,147,823	0	0	7,453,353	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/31/2020 7:53 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	0.153742	0	1,230,748	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.045788	0	90,168	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122484	0	383,579	0	0	54.00
60.00	06000	LABORATORY	0.371053	0	15,778	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.337251	0	133,947	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.275264	0	19,120	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.506603	0	70,125	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508006	0	298,955	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304711	0	130,896	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.106407	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	2,373,316	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	2,373,316	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/31/2020 7:53 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	189,218	0		50.00
53.00	05300	ANESTHESIOLOGY	4,129	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,982	0		54.00
60.00	06000	LABORATORY	5,854	0		60.00
66.00	06600	PHYSICAL THERAPY	45,174	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,263	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,526	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	151,871	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,885	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	523,902	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	523,902	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,300	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,300	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)	4,900	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	1,872	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	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)	12,263,426	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)	0	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,263,426	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)	12,263,426	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,946.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,643,998	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)	3,643,998	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	13,533,175	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,177,173	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)	929,897	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	863,700	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,793,597	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,383,576	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,400	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,946.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,725,212	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,129,457	12,263,426	0.255186	2,725,212	695,436	90.00
91.00	Nursing School cost	0	12,263,426	0.000000	2,725,212	0	91.00
92.00	Allied health cost	0	12,263,426	0.000000	2,725,212	0	92.00
93.00	All other Medical Education	0	12,263,426	0.000000	2,725,212	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/31/2020 7:53 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)	6,300	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,300	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)	4,900	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	35	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	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)	12,263,426	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)	0	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,263,426	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)	12,263,426	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,946.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	68,130	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)	68,130	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/31/2020 7:53 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)	155,911	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	224,041	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,400	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,946.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,725,212	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/31/2020 7:53 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	3,129,457	12,263,426	0.255186	2,725,212	695,436	90.00
91.00	Nursing School cost	0	12,263,426	0.000000	2,725,212	0	91.00
92.00	Allied health cost	0	12,263,426	0.000000	2,725,212	0	92.00
93.00	All other Medical Education	0	12,263,426	0.000000	2,725,212	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,297,760		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.153742	27,072,996	4,162,257	50.00
53.00	05300	ANESTHESIOLOGY	0.045788	1,200,563	54,971	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122484	284,262	34,818	54.00
60.00	06000	LABORATORY	0.371053	692,617	256,998	60.00
66.00	06600	PHYSICAL THERAPY	0.337251	1,153,938	389,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.275264	35,710	9,830	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.506603	1,365,864	691,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508006	14,272,655	7,250,594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304711	1,910,109	582,031	73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.106407	90,887	100,558	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		48,079,601	13,533,175	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)		48,079,601		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/31/2020 7:53 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		74,610		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.153742	445,582	68,505	50.00
53.00	05300	ANESTHESIOLOGY	0.045788	18,568	850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122484	2,577	316	54.00
60.00	06000	LABORATORY	0.371053	11,253	4,175	60.00
66.00	06600	PHYSICAL THERAPY	0.337251	15,268	5,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.275264	963	265	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.506603	25,388	12,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.508006	108,234	54,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304711	28,895	8,805	73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.106407	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		656,728	155,911	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)		656,728		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	11,485,518	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,197,864	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	53,836	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	23,325	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	34.16	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/31/2020 7:53 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	15,760,543		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	15,760,543	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,311,162	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	17,071,705	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	17,071,705	61.00
62.00	Deductibles billed to program beneficiaries	1,531,748	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	15,539,957	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-30,645	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A | Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,509,312	71.00
71.01	Sequestration adjustment (see instructions)		310,186	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		15,199,125	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/31/2020 7:53 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,453,353	2.00
3.00	OPPS payments	8,337,076	3.00
4.00	Outlier payment (see instructions)	2,552	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)	0	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)	0	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)	8,339,628	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	34,144	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,551,839	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)	6,753,645	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)	6,753,645	30.00
31.00	Primary payer payments	9,526	31.00
32.00	Subtotal (line 30 minus line 31)	6,744,119	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)	79,588	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	51,732	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	79,588	36.00
37.00	Subtotal (see instructions)	6,795,851	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)	6,795,851	40.00
40.01	Sequestration adjustment (see instructions)	135,917	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	6,609,240	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)	50,694	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 8/31/2020 7:53 am

Title XVIII | Hospital | PPS

		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		15,199,125		6,609,240	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15,199,125		6,609,240	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		1		50,694	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		15,199,126		6,659,934	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 | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII Date/Time Prepared: 8/31/2020 7:53 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	224,041		1.00
2.00	Medical and other services		523,902	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	224,041	523,902	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	224,041	523,902	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	656,728	2,373,316	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	656,728	2,373,316	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	656,728	2,373,316	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	432,687	1,849,414	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	224,041	523,902	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	224,041	523,902	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	224,041	523,902	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	224,041	523,902	36.00
37.00	TO ZERO OUT MEDICAID	-224,041	-523,902	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 8/31/2020 7:53 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	14,089,271	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	49,364,401	0	0	0	4.00
5.00	Other receivable	-30,154	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26,332,203	0	0	0	6.00
7.00	Inventory	810,476	0	0	0	7.00
8.00	Prepaid expenses	1,272,376	0	0	0	8.00
9.00	Other current assets	3,035,614	0	0	0	9.00
10.00	Due from other funds	139,818	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	42,349,599	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,947,195	0	0	0	12.00
13.00	Land improvements	3,753,536	0	0	0	13.00
14.00	Accumulated depreciation	-203,249	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	33,743,713	0	0	0	23.00
24.00	Accumulated depreciation	-25,442,849	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)	16,798,346	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	59,147,945	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,259,314	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,949,372	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	675,000	0	0	0	43.00
44.00	Other current liabilities	1,484,805	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,368,491	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,562,857	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,562,857	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,931,348	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	44,216,597				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)	44,216,597	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	59,147,945	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 8/31/2020 7:53 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		39,467,522		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		71,587,149				2.00
3.00	Total (sum of line 1 and line 2)		111,054,671		0		3.00
4.00	MEMBERSHIP ISSUED	-527,200		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-527,200		0		10.00
11.00	Subtotal (line 3 plus line 10)		110,527,471		0		11.00
12.00	DISTRIBUTIONS & MEMBERSHIP REDEEMED	66,310,874		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)		66,310,874		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,216,597		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	MEMBERSHIP ISSUED		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	DISTRIBUTIONS & MEMBERSHIP REDEEMED		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: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/31/2020 7:53 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,859,529		10,859,529	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,859,529		10,859,529	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)	10,859,529		10,859,529	17.00
18.00	Ancillary services	129,842,701	268,907,174	398,749,875	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	140,702,230	268,907,174	409,609,404	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		110,382,143		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)		110,382,143		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 8/31/2020 7:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	409,609,404	1.00
2.00	Less contractual allowances and discounts on patients' accounts	230,673,515	2.00
3.00	Net patient revenues (line 1 minus line 2)	178,935,889	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	110,382,143	4.00
5.00	Net income from service to patients (line 3 minus line 4)	68,553,746	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	606	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	392,108	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	APPLICATION FEE & LEARNING LAB	30,720	24.00
24.01	OTHER MISCELLANEOUS INCOME	2,609,969	24.01
25.00	Total other income (sum of lines 6-24)	3,033,403	25.00
26.00	Total (line 5 plus line 25)	71,587,149	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)	71,587,149	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/31/2020 7:53 am
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,297,306	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		13,856	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		13.42	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,311,162	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00