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: 15-1310	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/28/2020 4:40 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/28/2020 Time: 4:40 pm
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 PARKVIEW WABASH HOSPITAL, INC. (15-1310) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) JEANNE WICKENS
Officer or Administrator of Provider(s)

CFO/SVP
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	69,216	-1,487,064	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
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RHC - CASS ST I	0		-117,413		0	10.00
10.01	RHC - N. MANCHESTER II	0		56,271		0	10.01
10.02	RHC - KISSINGER III	0		53,024		0	10.02
200.00	Total	0	69,216	-1,495,182	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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2020 4:40 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 10 JOHN KISSINGER DR	PO Box:			1.00
2.00	City: WABASH	State: IN	Zip Code: 46992	County: WABASH	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	PARKVIEW WABASH HOSPITAL, INC.	151310	99915	1	12/17/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARKVIEW WABASH HOSPITAL SWING BEDS	15Z310	99915		12/17/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	RURAL HEALTH CLINIC - CASS ST	158544	99915		05/30/2019	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	RURAL HEALTH CLINIC - N.MANCHESTER	158541	99915		06/05/2019	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	RURAL HEALTH CLINIC - KISSINGER	158542	99915		07/24/2019	N	N	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 4:40 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 4:40 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 4:40 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1310	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 4:40 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2020 4:40 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	4,549	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
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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2020 4:40 pm

	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: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845	143.00

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

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

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

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

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

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

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

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 7/28/2020 4:40 pm

		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)	N			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	03/27/2020	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.	Y	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.	Y	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	05/01/2020	Y	05/01/2020	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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 7/28/2020 4:40 pm

		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.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2603738406	ERIC.NICKESON@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1310	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/28/2020 4:40 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 7/28/2020 4:40 pm

	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	18	6,570	82,392.00	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)		18	6,570	82,392.00	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	43.00				0	13.00
14.00	Total (see instructions)		18	6,570	82,392.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CASS ST	88.00				0	26.00
26.01	RHC - N. MANCHESTER	88.01				0	26.01
26.02	RHC - KISSINGER	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		18				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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 7/28/2020 4:40 pm

	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)	1,327	85	3,273			1.00
2.00	HMO and other (see instructions)	1,154	91				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	1			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,327	85	3,274			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		88	159			13.00
14.00	Total (see instructions)	1,327	173	3,433	0.00	171.50	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CASS ST	1,781	186	12,220	0.00	9.89	26.00
26.01	RHC - N. MANCHESTER	1,637	58	7,165	0.00	7.91	26.01
26.02	RHC - KISSINGER	1,006	44	3,310	0.00	3.44	26.02
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	192.74	27.00
28.00	Observation Bed Days		86	1,434			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			11			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	6	67			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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 7/28/2020 4:40 pm

	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	493	39	1,275	1.00
2.00	HMO and other (see instructions)			404	74		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	493	39	1,275	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CASS ST	0.00					26.00
26.01	RHC - N. MANCHESTER	0.00					26.01
26.02	RHC - KISSINGER	0.00					26.02
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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-8544 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC I

				1.00		
	Clinic Address and Identification					
1.00	Street			1655 N CASS ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WABASH		IN	46992	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-8544 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC I

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC II

				1.00		
	Clinic Address and Identification					
1.00	Street			1104 N. WAYNE ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NORTH MANCHESTER		IN	46962	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC II

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC III

				1.00		
	Clinic Address and Identification					
1.00	Street			8 JOHN KISSINGER DR.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WABASH		IN	46992	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

	1.00	2.00	
12.00 Have you received an approval for an exception to the productivity standard?	N		12.00
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC III

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 7/28/2020 4:40 pm

		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)	0.276998	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,190,891	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	11,224,575	6.00
7.00	Medicaid cost (line 1 times line 6)	3,109,185	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)	1,918,294	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	51,417	9.00
10.00	Stand-alone CHIP charges	320,213	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	88,698	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	37,281	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)	1,398,314	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	13,078,134	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	3,622,617	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)	2,224,303	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)	4,179,878	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,550,271	889,495	3,439,766	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	706,420	889,495	1,595,915	21.00
22.00	Payments received from patients for amounts previously written off as charity care	48,436	5,141	53,577	22.00
23.00	Cost of charity care (line 21 minus line 22)	657,984	884,354	1,542,338	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)	4,092,852	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	590,215	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	908,023	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,184,829	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,199,999	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,742,337	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,922,215	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 7/28/2020 4:40 pm

		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		3,762,194	3,762,194	-772,319	2,989,875	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,823,578	1,823,578	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	86,616	5,645,595	5,732,211	-2,193	5,730,018	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	644,367	13,608,290	14,252,657	-52,122	14,200,535	5.00
7.00	00700	OPERATION OF PLANT	289,317	760,610	1,049,927	-1,803	1,048,124	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	226,003	260,459	486,462	0	486,462	9.00
10.00	01000	DIETARY	501,949	343,611	845,560	-617,513	228,047	10.00
11.00	01100	CAFETERIA	0	0	0	608,637	608,637	11.00
13.00	01300	NURSING ADMINISTRATION	503,694	57,768	561,462	-2,896	558,566	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	708,665	254,634	963,299	-30,368	932,931	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,114,176	1,215,001	3,329,177	-531,706	2,797,471	30.00
43.00	04300	NURSERY	0	0	0	91,446	91,446	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	806,862	1,059,722	1,866,584	-97,037	1,769,547	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	437,777	437,777	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	917,150	696,670	1,613,820	-2,169	1,611,651	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	1,829,416	1,829,416	0	1,829,416	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,042,619	216,694	1,259,313	-371,537	887,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	158,306	158,306	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	104,392	104,392	68.00
69.00	06900	ELECTROCARDIOLOGY	503,227	66,279	569,506	-1,339	568,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,776,675	1,776,675	-733,633	1,043,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	733,633	733,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,637,066	3,637,066	33,955	3,671,021	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	1,504,160	1,504,160	0	1,504,160	88.00
88.01	08801	RHC - N. MANCHESTER	0	1,390,471	1,390,471	0	1,390,471	88.01
88.02	08802	RHC - KISSINGER	0	607,650	607,650	0	607,650	88.02
90.00	09000	CLINIC	0	146,850	146,850	8,876	155,726	90.00
90.01	09001	SENIOR CARE	172,448	110,360	282,808	-50	282,758	90.01
91.00	09100	EMERGENCY	900,554	2,486,996	3,387,550	-3,555	3,383,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	214,628	214,628	0	214,628	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		780,360	780,360	-780,360	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,417,647	42,432,159	51,849,806	0	51,849,806	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,536	12,616	29,152	0	29,152	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	121,769	235,491	357,260	0	357,260	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	1,182,772	1,182,772	0	1,182,772	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	955,370	955,370	0	955,370	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	738,185	738,185	0	738,185	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	-101,399	-101,399	0	-101,399	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	55,504	55,504	0	55,504	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	9,555,952	45,510,698	55,066,650	0	55,066,650	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 7/28/2020 4:40 pm

		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	-169,864	2,820,011		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-39,545	1,784,033		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,362,977	4,367,041		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,328,277	10,872,258		5.00
7.00	00700	OPERATION OF PLANT	-100,040	948,084		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	486,462		9.00
10.00	01000	DIETARY	-4,979	223,068		10.00
11.00	01100	CAFETERIA	-252,641	355,996		11.00
13.00	01300	NURSING ADMINISTRATION	0	558,566		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-91,513	841,418		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-372,204	2,425,267		30.00
43.00	04300	NURSERY	0	91,446		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,769,547		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	437,777		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-35,155	1,576,496		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	1,829,416		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	887,776		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	158,306		67.00
68.00	06800	SPEECH PATHOLOGY	0	104,392		68.00
69.00	06900	ELECTROCARDIOLOGY	0	568,167		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,043,042		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	733,633		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,671,021		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CASS ST	-22,510	1,481,650		88.00
88.01	08801	RHC - N. MANCHESTER	-28,126	1,362,345		88.01
88.02	08802	RHC - KISSINGER	-30	607,620		88.02
90.00	09000	CLINIC	0	155,726		90.00
90.01	09001	SENIOR CARE	0	282,758		90.01
91.00	09100	EMERGENCY	-858,598	2,525,397		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-214,628	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,881,087	44,968,719		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-15,202	13,950		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	357,260		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	1,182,772		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	955,370		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	738,185		192.03
194.00	07950	FITNESS CENTER	0	0		194.00
194.01	07951	FOUNDATION	322,676	221,277		194.01
194.02	07952	NEW DIRECTION	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	-113	55,391		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,573,726	48,492,924		200.00

RECLASSIFICATIONS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 7/28/2020 4:40 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - REHAB THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	129,503	28,803	1.00
2.00	SPEECH PATHOLOGY	68.00	85,398	18,994	2.00
	0		214,901	47,797	
	B - CLINIC DIETICIAN				
1.00	CLINIC	90.00	8,876	0	1.00
	0		8,876	0	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	358,681	249,956	1.00
	0		358,681	249,956	
	D - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	33,955	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	33,955	
	E - SALARY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	4,394,731	0	1.00
	0		4,394,731	0	
	G - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,678,768	1.00
	0		0	1,678,768	
	H - EQUIP & BLDG LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98,775	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	131,880	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
14.00		0.00	0	0	14.00
	0		0	230,655	
	I - IMPLANTABLE MEDICAL SUP.				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	733,633	1.00
	0		0	733,633	
	K - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	780,360	1.00
	0		0	780,360	
	L - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27,314	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,930	2.00
	0		0	40,244	
	M - OB RECLASS				
1.00	NURSERY	43.00	23,936	67,510	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	114,589	323,188	2.00
	0		138,525	390,698	
500.00	Grand Total: Increases		5,115,714	4,186,066	500.00

RECLASSIFICATIONS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 7/28/2020 4:40 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - REHAB THERAPY RECLASS					
1.00	PHYSICAL THERAPY	66.00	214,901	47,797	0	1.00
2.00		0.00	0	0	0	2.00
	0		214,901	47,797		
	B - CLINIC DIETICIAN					
1.00	DIETARY	10.00	8,876	0	0	1.00
	0		8,876	0		
	C - CAFETERIA RECLASS					
1.00	DIETARY	10.00	358,681	249,956	0	1.00
	0		358,681	249,956		
	D - DRUGS CHARGED TO PATIENTS					
1.00	PHARMACY	15.00	0	27,958	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	294	0	2.00
3.00	OPERATING ROOM	50.00	0	5,665	0	3.00
4.00	EMERGENCY	91.00	0	38	0	4.00
	0		0	33,955		
	E - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,394,731	0	1.00
	0		0	4,394,731		
	G - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,678,768	9	1.00
	0		0	1,678,768		
	H - EQUIP & BLDG LEASE					
1.00	PHYSICAL THERAPY	66.00	0	98,775	10	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,875	10	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,193	10	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	11,878	10	4.00
5.00	OPERATION OF PLANT	7.00	0	1,803	10	5.00
6.00	NURSING ADMINISTRATION	13.00	0	2,896	10	6.00
7.00	PHARMACY	15.00	0	2,410	10	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	2,483	10	8.00
9.00	OPERATING ROOM	50.00	0	91,372	10	9.00
10.00	ELECTROCARDIOLOGY	69.00	0	1,339	10	10.00
11.00	PHYSICAL THERAPY	66.00	0	10,064	10	11.00
12.00	EMERGENCY	91.00	0	3,517	10	12.00
14.00	SENIOR CARE	90.01	0	50	10	14.00
	0		0	230,655		
	I - IMPLANTABLE MEDICAL SUP.					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	733,633	0	1.00
	0		0	733,633		
	K - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	780,360	11	1.00
	0		0	780,360		
	L - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,244	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	40,244		
	M - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	138,525	390,698	0	1.00
2.00		0.00	0	0	0	2.00
	0		138,525	390,698		
500.00	Grand Total: Decreases		720,983	8,580,797		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 7/28/2020 4:40 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	1,518,481	0	0	0	0	1.00
2.00	Land Improvements	1,032,463	1,111,139	0	1,111,139	0	2.00
3.00	Buildings and Fixtures	44,202,127	402,184	0	402,184	0	3.00
4.00	Building Improvements	4,150,859	0	0	0	0	4.00
5.00	Fixed Equipment	2,762,870	0	0	0	0	5.00
6.00	Movable Equipment	23,811,790	359,989	0	359,989	0	6.00
7.00	HIT designated Assets	2,346,516	114,560	0	114,560	768,710	7.00
8.00	Subtotal (sum of lines 1-7)	79,825,106	1,987,872	0	1,987,872	768,710	8.00
9.00	Reconciling Items	552,721	0	0	0	552,721	9.00
10.00	Total (line 8 minus line 9)	79,272,385	1,987,872	0	1,987,872	215,989	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,518,481	0	1.00
2.00	Land Improvements	2,143,602	314,699	2.00
3.00	Buildings and Fixtures	44,604,311	33,184,215	3.00
4.00	Building Improvements	4,150,859	3,377,792	4.00
5.00	Fixed Equipment	2,762,870	769,970	5.00
6.00	Movable Equipment	24,171,779	13,887,258	6.00
7.00	HIT designated Assets	1,692,366	1,821,935	7.00
8.00	Subtotal (sum of lines 1-7)	81,044,268	53,355,869	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	81,044,268	53,355,869	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 7/28/2020 4:40 pm

	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	3,762,194	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,762,194	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,762,194	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	3,762,194	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 7/28/2020 4:40 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	55,180,123	0	55,180,123	0.702183	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,403,609	0	23,403,609	0.297817	0	2.00
3.00	Total (sum of lines 1-2)	78,583,732	0	78,583,732	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,913,562	98,775	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,639,223	131,880	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,552,785	230,655	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	780,360	27,314	0	0	2,820,011	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,930	0	0	1,784,033	2.00
3.00	Total (sum of lines 1-2)	780,360	40,244	0	0	4,604,044	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 7/28/2020 4:40 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
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	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,273,182			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	-1,359,496			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-252,641	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-82,500	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
19.03	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.03
20.00	Vending machines	B	0	OPERATION OF PLANT	7.00	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 7/28/2020 4:40 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DEPRECIATION - - HIT ASSETS 2016	A	-4,111	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	DEPRECIATION - - HIT ASSETS PRIOR	A	-138,708	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	DEPRECIATION-OLD HOSP	A	-169,864	CAP REL COSTS-BLDG & FIXT	1.00	9	33.02
34.00	RECRUITMENT	A	-4,190	ADMINISTRATIVE & GENERAL	5.00	0	34.00
38.00	SELF INSURANCE ADJUSTMENT	A	-1,362,977	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	LOBBYING	A	-4,082	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MARKETING	A	-153	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	TELEVISION	A	-1,987	OPERATION OF PLANT	7.00	0	40.01
40.02	MARKETING	A	-113	COMMUNITY & VOLUNTEER SERVICES	194.03	0	40.02
40.03	340B RETAIL	A	-9,013	PHARMACY	15.00	0	40.03
42.00	LIQUOR ADJUSTMENT	A	-225	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.01	OTHER OPERATING REVENUE	A	-2,419	ADMINISTRATIVE & GENERAL	5.00	0	42.01
42.02	TV	A	-39,545	CAP REL COSTS-MVBLE EQUIP	2.00	9	42.02
44.00	EMS ADJUSTMENT	A	-204,044	AMBULANCE SERVICES	95.00	0	44.00
45.00	TELEMETRY MONITORING	A	31,796	ADULTS & PEDIATRICS	30.00	0	45.00
45.01	RHC N MANCHESTER ADJUSTMENTS (M-1)	A	-28,126	RHC - N. MANCHESTER	88.01	0	45.01
45.02	PURCHASING DISCOUNTS	A	-4,811	ADMINISTRATIVE & GENERAL	5.00	0	45.02
46.01	HHH ADJUSTMENT	A	-18,911	ADMINISTRATIVE & GENERAL	5.00	0	46.01
48.00	OTHER OPERATING REV	A	-280	RADIOLOGY-DIAGNOSTIC	54.00	0	48.00
49.00	OTHER OPERATING REV	A	-4,979	DIETARY	10.00	0	49.00
49.01	OTHER OPERATING REV	A	-15,202	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	49.01
49.02	HEARTSMART SCAN READS	A	-34,875	RADIOLOGY-DIAGNOSTIC	54.00	0	49.02
49.03	HAF FEE EXPENSE ADJUSTMENT	A	-1,791,171	ADMINISTRATIVE & GENERAL	5.00	0	49.03
49.04	HOSPITALIST AVAILABILITY COVERAGE	A	0	ADULTS & PEDIATRICS	30.00	0	49.04
49.05	PHYSICIAN CLINIC RENT OFFSET	B	-98,053	OPERATION OF PLANT	7.00	0	49.05
49.06	REMOVE FOUNDATION REVENUE	A	322,676	FOUNDATION	194.01	0	49.06
49.07	RHC CASS ADJUSTMENTS (M-1)	A	-22,510	RHC - CASS ST	88.00	0	49.07
49.08	RHC KISSINGER ADJUSTMENTS (M-1)	A	-30	RHC - KISSINGER	88.02	0	49.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,573,726				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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 7/28/2020 4:40 pm

	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	HOME OFFICE ALLOCATION	9,434,574	6,929,388	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY (PPG)	0	3,864,682	2.00
3.00	0.00			0	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.			9,434,574	10,794,070	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1310	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 7/28/2020 4:40 pm

	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	2,505,186	0		1.00
2.00	-3,864,682	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,359,496			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	HEALTH SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 7/28/2020 4:40 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,971,000	858,598	1,112,402	0	0	1.00
2.00	90.01	SENIOR CARE	32,677	0	32,677	0	0	2.00
3.00	95.00	AMBULANCE SERVICES	10,584	10,584	0	0	0	3.00
4.00	30.00	DR. F	404,000	404,000	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,418,261	1,273,182	1,145,079		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	90.01	SENIOR CARE	0	0	0	0	0	2.00
3.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	3.00
4.00	30.00	DR. F	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	858,598		1.00
2.00	90.01	SENIOR CARE	0	0	0	0		2.00
3.00	95.00	AMBULANCE SERVICES	0	0	0	10,584		3.00
4.00	30.00	DR. F	0	0	0	404,000		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,273,182		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,820,011	2,820,011				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,784,033		1,784,033			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,367,041	0	0	4,367,041		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,872,258	789,416	499,414	1,587,264	13,748,352	5.00
7.00	00700	OPERATION OF PLANT	948,084	327,273	207,044	91,132	1,573,533	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	486,462	61,669	39,014	71,189	658,334	9.00
10.00	01000	DIETARY	223,068	70,727	44,744	42,332	380,871	10.00
11.00	01100	CAFETERIA	355,996	126,258	79,875	112,981	675,110	11.00
13.00	01300	NURSING ADMINISTRATION	558,566	5,435	3,438	158,659	726,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	841,418	104,334	66,005	223,222	1,234,979	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,425,267	256,583	162,323	622,310	3,466,483	30.00
43.00	04300	NURSERY	91,446	3,808	2,409	7,540	105,203	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,769,547	278,840	176,403	254,153	2,478,943	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	437,777	31,426	19,881	36,094	525,178	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,576,496	234,955	148,640	288,893	2,248,984	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,829,416	128,809	81,489	0	2,039,714	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	887,776	13,680	8,654	260,723	1,170,833	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,306	0	0	40,792	199,098	67.00
68.00	06800	SPEECH PATHOLOGY	104,392	0	0	26,900	131,292	68.00
69.00	06900	ELECTROCARDIOLOGY	568,167	105,628	66,824	158,511	899,130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,043,042	0	0	0	1,043,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	733,633	0	0	0	733,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,671,021	0	0	0	3,671,021	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	1,481,650	0	0	0	1,481,650	88.00
88.01	08801	RHC - N. MANCHESTER	1,362,345	0	0	0	1,362,345	88.01
88.02	08802	RHC - KISSINGER	607,620	0	0	0	607,620	88.02
90.00	09000	CLINIC	155,726	4,215	2,666	2,796	165,403	90.00
90.01	09001	SENIOR CARE	282,758	37,304	23,600	54,319	397,981	90.01
91.00	09100	EMERGENCY	2,525,397	215,397	136,267	283,666	3,160,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,968,719	2,795,757	1,768,690	4,323,476	44,885,557	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,950	14,715	9,309	5,209	43,183	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	357,260	0	0	38,356	395,616	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	1,182,772	0	0	0	1,182,772	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	955,370	0	0	0	955,370	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	738,185	0	0	0	738,185	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	221,277	9,539	6,034	0	236,850	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	55,391	0	0	0	55,391	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	48,492,924	2,820,011	1,784,033	4,367,041	48,492,924	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,748,352					5.00
7.00	00700	OPERATION OF PLANT	622,644	2,196,177				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	260,501	79,513	0	998,348		9.00
10.00	01000	DIETARY	150,710	91,192	0	43,012	665,785	10.00
11.00	01100	CAFETERIA	267,140	162,791	0	76,782	0	11.00
13.00	01300	NURSING ADMINISTRATION	287,316	7,007	0	3,305	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	488,679	134,523	0	63,449	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,371,680	330,826	0	156,038	665,785	30.00
43.00	04300	NURSERY	41,629	4,910	0	2,316	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	980,913	359,523	0	169,571	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	207,812	40,519	0	19,111	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	889,918	302,939	0	142,885	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	807,111	166,080	0	78,334	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	463,296	17,638	0	8,319	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,783	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	51,952	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	355,784	136,191	0	64,236	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	412,730	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	290,297	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,452,610	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	586,286	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	539,077	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	240,434	0	0	0	0	88.02
90.00	09000	CLINIC	65,450	5,434	0	2,563	0	90.00
90.01	09001	SENIOR CARE	157,480	48,098	0	22,686	0	90.01
91.00	09100	EMERGENCY	1,250,693	277,722	0	130,991	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,320,925	2,164,906	0	983,598	665,785	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,087	18,972	0	8,949	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	156,544	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	468,021	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	378,038	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	292,098	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	93,721	12,299	0	5,801	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	21,918	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	13,748,352	2,196,177	0	998,348	665,785	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,181,823					11.00
13.00	01300	NURSING ADMINISTRATION	52,311	1,076,037				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	84,355	0	0	2,005,985		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	334,662	467,341	0	40,329	0	30.00
43.00	04300	NURSERY	0	23,884	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	115,445	208,949	0	7,158	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	114,323	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,789	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,849	0	0	18,888	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	2,084	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	139,743	0	0	124,416	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,370	0	0	10,351	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,823	0	0	2,117	0	68.00
69.00	06900	ELECTROCARDIOLOGY	83,506	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,744,148	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	0	0	0	0	0	88.02
90.00	09000	CLINIC	1,486	0	0	0	0	90.00
90.01	09001	SENIOR CARE	28,755	261,540	0	0	0	90.01
91.00	09100	EMERGENCY	144,518	0	0	23,122	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,181,823	1,076,037	0	1,975,402	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	30,583	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	1,181,823	1,076,037	0	2,005,985	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,833,144	0	6,833,144		30.00
43.00	04300	NURSERY	177,942	0	177,942		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,320,502	0	4,320,502		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	906,943	0	906,943		52.00
53.00	05300	ANESTHESIOLOGY	2,789	0	2,789		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,776,463	0	3,776,463		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	3,093,323	0	3,093,323		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	1,924,245	0	1,924,245		66.00
67.00	06700	OCCUPATIONAL THERAPY	301,602	0	301,602		67.00
68.00	06800	SPEECH PATHOLOGY	196,184	0	196,184		68.00
69.00	06900	ELECTROCARDIOLOGY	1,538,847	0	1,538,847		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,455,772	0	1,455,772		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,023,930	0	1,023,930		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,867,779	0	6,867,779		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CASS ST	2,067,936	0	2,067,936		88.00
88.01	08801	RHC - N. MANCHESTER	1,901,422	0	1,901,422		88.01
88.02	08802	RHC - KISSINGER	848,054	0	848,054		88.02
90.00	09000	CLINIC	240,336	0	240,336		90.00
90.01	09001	SENIOR CARE	916,540	0	916,540		90.01
91.00	09100	EMERGENCY	4,987,773	0	4,987,773		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,381,526	0	43,381,526		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,191	0	88,191		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	552,160	0	552,160		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	1,650,793	0	1,650,793		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	1,333,408	0	1,333,408		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	1,030,283	0	1,030,283		192.03
194.00	07950	FITNESS CENTER	0	0	0		194.00
194.01	07951	FOUNDATION	379,254	0	379,254		194.01
194.02	07952	NEW DIRECTION	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	77,309	0	77,309		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	48,492,924	0	48,492,924		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/28/2020 4:40 pm

		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	848,390	789,416	499,414	2,137,220	0	5.00
7.00	00700	OPERATION OF PLANT	0	327,273	207,044	534,317	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	61,669	39,014	100,683	0	9.00
10.00	01000	DIETARY	0	70,727	44,744	115,471	0	10.00
11.00	01100	CAFETERIA	0	126,258	79,875	206,133	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,435	3,438	8,873	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	104,334	66,005	170,339	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	256,583	162,323	418,906	0	30.00
43.00	04300	NURSERY	0	3,808	2,409	6,217	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	278,840	176,403	455,243	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,426	19,881	51,307	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	234,955	148,640	383,595	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	128,809	81,489	210,298	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	13,680	8,654	22,334	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	105,628	66,824	172,452	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	4,215	2,666	6,881	0	90.00
90.01	09001	SENIOR CARE	0	37,304	23,600	60,904	0	90.01
91.00	09100	EMERGENCY	0	215,397	136,267	351,664	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	848,390	2,795,757	1,768,690	5,412,837	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,715	9,309	24,024	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	9,539	6,034	15,573	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	848,390	2,820,011	1,784,033	5,452,434	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,137,220					5.00
7.00	00700	OPERATION OF PLANT	96,791	631,108				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	40,495	22,849	0	164,027		9.00
10.00	01000	DIETARY	23,428	26,205	0	7,067	172,171	10.00
11.00	01100	CAFETERIA	41,527	46,781	0	12,615	0	11.00
13.00	01300	NURSING ADMINISTRATION	44,664	2,014	0	543	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	75,966	38,657	0	10,425	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	213,230	95,068	0	25,637	172,171	30.00
43.00	04300	NURSERY	6,471	1,411	0	380	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	152,485	103,315	0	27,860	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,305	11,644	0	3,140	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	138,340	87,055	0	23,476	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	125,467	47,726	0	12,870	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	72,020	5,068	0	1,367	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,247	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,076	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	55,307	39,137	0	10,554	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,160	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,127	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	225,824	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	91,139	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	83,801	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	37,376	0	0	0	0	88.02
90.00	09000	CLINIC	10,174	1,562	0	421	0	90.00
90.01	09001	SENIOR CARE	24,481	13,822	0	3,727	0	90.01
91.00	09100	EMERGENCY	194,423	79,808	0	21,522	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,915,324	622,122	0	161,604	172,171	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,656	5,452	0	1,470	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,335	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	72,755	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	58,767	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	45,407	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	14,569	3,534	0	953	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	3,407	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	2,137,220	631,108	0	164,027	172,171	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	307,056					11.00
13.00	01300	NURSING ADMINISTRATION	13,591	69,685				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	21,917	0	0	317,304		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	86,951	30,264	0	6,379	0	30.00
43.00	04300	NURSERY	0	1,547	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,994	13,532	0	1,132	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,404	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	441	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,909	0	0	2,988	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	330	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	36,307	0	0	19,680	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,474	0	0	1,637	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,812	0	0	335	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,696	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	275,887	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	0	0	0	0	0	88.02
90.00	09000	CLINIC	386	0	0	0	0	90.00
90.01	09001	SENIOR CARE	7,471	16,938	0	0	0	90.01
91.00	09100	EMERGENCY	37,548	0	0	3,657	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	307,056	69,685	0	312,466	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	4,838	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	307,056	69,685	0	317,304	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,048,606	0	1,048,606		30.00
43.00	04300	NURSERY	16,026	0	16,026		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	783,561	0	783,561		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	105,800	0	105,800		52.00
53.00	05300	ANESTHESIOLOGY	441	0	441		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	680,363	0	680,363		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	396,691	0	396,691		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	156,776	0	156,776		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,358	0	17,358		67.00
68.00	06800	SPEECH PATHOLOGY	11,223	0	11,223		68.00
69.00	06900	ELECTROCARDIOLOGY	299,146	0	299,146		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,160	0	64,160		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,127	0	45,127		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	501,711	0	501,711		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CASS ST	91,139	0	91,139		88.00
88.01	08801	RHC - N. MANCHESTER	83,801	0	83,801		88.01
88.02	08802	RHC - KISSINGER	37,376	0	37,376		88.02
90.00	09000	CLINIC	19,424	0	19,424		90.00
90.01	09001	SENIOR CARE	127,343	0	127,343		90.01
91.00	09100	EMERGENCY	688,622	0	688,622		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,174,694	0	5,174,694		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,602	0	33,602		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,335	0	24,335		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	72,755	0	72,755		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	58,767	0	58,767		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	45,407	0	45,407		192.03
194.00	07950	FITNESS CENTER	0	0	0		194.00
194.01	07951	FOUNDATION	39,467	0	39,467		194.01
194.02	07952	NEW DIRECTION	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	3,407	0	3,407		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	5,452,434	0	5,452,434		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	76,275					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		76,275				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	13,864,067			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,352	21,352	5,039,098	-13,748,352	34,744,572	5.00
7.00	00700	OPERATION OF PLANT	8,852	8,852	289,317	0	1,573,533	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,668	1,668	226,003	0	658,334	9.00
10.00	01000	DIETARY	1,913	1,913	134,392	0	380,871	10.00
11.00	01100	CAFETERIA	3,415	3,415	358,681	0	675,110	11.00
13.00	01300	NURSING ADMINISTRATION	147	147	503,694	0	726,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,822	2,822	708,665	0	1,234,979	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,940	6,940	1,975,651	0	3,466,483	30.00
43.00	04300	NURSERY	103	103	23,936	0	105,203	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,542	7,542	806,862	0	2,478,943	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	850	850	114,589	0	525,178	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,355	6,355	917,150	0	2,248,984	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	3,484	3,484	0	0	2,039,714	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	370	370	827,718	0	1,170,833	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	129,503	0	199,098	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	85,398	0	131,292	68.00
69.00	06900	ELECTROCARDIOLOGY	2,857	2,857	503,227	0	899,130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,043,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	733,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,671,021	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	0	1,481,650	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	0	1,362,345	88.01
88.02	08802	RHC - KISSINGER	0	0	0	0	607,620	88.02
90.00	09000	CLINIC	114	114	8,876	0	165,403	90.00
90.01	09001	SENIOR CARE	1,009	1,009	172,448	0	397,981	90.01
91.00	09100	EMERGENCY	5,826	5,826	900,554	0	3,160,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,619	75,619	13,725,762	-13,748,352	31,137,205	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	398	398	16,536	0	43,183	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	121,769	0	395,616	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	1,182,772	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	955,370	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	738,185	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	258	258	0	0	236,850	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	55,391	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	2,820,011	1,784,033	4,367,041		13,748,352	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.971629	23.389485	0.314990		0.395698	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		2,137,220	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.061512	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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		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	46,071					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900	HOUSEKEEPING	1,668	0	44,403			9.00
10.00	01000	DIETARY	1,913	0	1,913	3,274		10.00
11.00	01100	CAFETERIA	3,415	0	3,415	0	11,138	11.00
13.00	01300	NURSING ADMINISTRATION	147	0	147	0	493	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,822	0	2,822	0	795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,940	0	6,940	3,274	3,154	30.00
43.00	04300	NURSERY	103	0	103	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,542	0	7,542	0	1,088	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	850	0	850	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,355	0	6,355	0	1,629	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	3,484	0	3,484	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	370	0	370	0	1,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	126	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	102	68.00
69.00	06900	ELECTROCARDIOLOGY	2,857	0	2,857	0	787	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	0	0	0	0	0	88.02
90.00	09000	CLINIC	114	0	114	0	14	90.00
90.01	09001	SENIOR CARE	1,009	0	1,009	0	271	90.01
91.00	09100	EMERGENCY	5,826	0	5,826	0	1,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,415	0	43,747	3,274	11,138	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	398	0	398	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	258	0	258	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	2,196,177	0	998,348	665,785	1,181,823	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.669402	0.000000	22.483796	203.355223	106.107290	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	631,108	0	164,027	172,171	307,056	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.698596	0.000000	3.694052	52.587355	27.568325	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)		
			13.00	14.00	15.00	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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	116,910					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	59,688			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	9,999		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,776	0	1,200	757		30.00
43.00	04300	NURSERY	2,595	0	0	38		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,702	0	213	114		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,421	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	83	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	562	4,068		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
60.00	06000	LABORATORY	0	0	62	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	0	3,702	2,127		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	308	157		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	63	72		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	51,897	0		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	0		88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	0		88.01
88.02	08802	RHC - KISSINGER	0	0	0	0		88.02
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	SENIOR CARE	28,416	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	688	2,666		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,910	0	58,778	9,999		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0		192.03
194.00	07950	FITNESS CENTER	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	910	0		194.01
194.02	07952	NEW DIRECTION	0	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0		194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,076,037	0	2,005,985	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.203977	0.000000	33.607844	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	69,685	0	317,304	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.596057	0.000000	5.316043	0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/28/2020 4:40 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)		
			13.00	14.00	15.00	16.00		
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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,833,144		6,833,144	0	0	30.00
43.00	04300	NURSERY	177,942		177,942	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,320,502		4,320,502	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	906,943		906,943	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,789		2,789	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,776,463		3,776,463	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	3,093,323		3,093,323	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,924,245	0	1,924,245	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,602	0	301,602	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	196,184	0	196,184	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,538,847		1,538,847	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,455,772		1,455,772	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,023,930		1,023,930	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,867,779		6,867,779	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	2,067,936		2,067,936	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	1,901,422		1,901,422	0	0	88.01
88.02	08802	RHC - KISSINGER	848,054		848,054	0	0	88.02
90.00	09000	CLINIC	240,336		240,336	0	0	90.00
90.01	09001	SENIOR CARE	916,540		916,540	0	0	90.01
91.00	09100	EMERGENCY	4,987,773		4,987,773	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,081,695		2,081,695		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	45,463,221	0	45,463,221	0	0	200.00
201.00		Less Observation Beds	2,081,695		2,081,695		0	201.00
202.00		Total (see instructions)	43,381,526	0	43,381,526	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,196,567		6,196,567			30.00
43.00	04300	NURSERY	218,492		218,492			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,802,703	14,242,227	17,044,930	0.253477	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,045,982	0	1,045,982	0.867073	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	338,399	2,210,669	2,549,068	0.001094	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,482,481	27,613,558	29,096,039	0.129793	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
60.00	06000	LABORATORY	2,236,099	16,465,077	18,701,176	0.165408	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	332,965	4,581,259	4,914,224	0.391566	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,911	308,693	493,604	0.611020	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	60,145	169,654	229,799	0.853720	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,511,980	4,400,031	5,912,011	0.260292	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	720,363	3,153,687	3,874,050	0.375775	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	783,858	4,077,725	4,861,583	0.210617	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,183,212	26,192,102	29,375,314	0.233794	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	2,088,790	2,088,790			88.00
88.01	08801	RHC - N. MANCHESTER	0	1,645,804	1,645,804			88.01
88.02	08802	RHC - KISSINGER	0	694,647	694,647			88.02
90.00	09000	CLINIC	0	1,137,734	1,137,734	0.211241	0.000000	90.00
90.01	09001	SENIOR CARE	0	932,533	932,533	0.982850	0.000000	90.01
91.00	09100	EMERGENCY	957,318	22,030,133	22,987,451	0.216978	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,613,113	2,613,113	0.796634	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	22,055,475	134,557,436	156,612,911			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,055,475	134,557,436	156,612,911			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC - CASS ST			88.00
88.01	08801	RHC - N. MANCHESTER			88.01
88.02	08802	RHC - KISSINGER			88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,833,144		6,833,144	0	6,833,144	30.00
43.00	04300	NURSERY	177,942		177,942	0	177,942	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,320,502		4,320,502	0	4,320,502	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	906,943		906,943	0	906,943	52.00
53.00	05300	ANESTHESIOLOGY	2,789		2,789	0	2,789	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,776,463		3,776,463	0	3,776,463	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	3,093,323		3,093,323	0	3,093,323	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,924,245	0	1,924,245	0	1,924,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,602	0	301,602	0	301,602	67.00
68.00	06800	SPEECH PATHOLOGY	196,184	0	196,184	0	196,184	68.00
69.00	06900	ELECTROCARDIOLOGY	1,538,847		1,538,847	0	1,538,847	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,455,772		1,455,772	0	1,455,772	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,023,930		1,023,930	0	1,023,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,867,779		6,867,779	0	6,867,779	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	2,067,936		2,067,936	0	2,067,936	88.00
88.01	08801	RHC - N. MANCHESTER	1,901,422		1,901,422	0	1,901,422	88.01
88.02	08802	RHC - KISSINGER	848,054		848,054	0	848,054	88.02
90.00	09000	CLINIC	240,336		240,336	0	240,336	90.00
90.01	09001	SENIOR CARE	916,540		916,540	0	916,540	90.01
91.00	09100	EMERGENCY	4,987,773		4,987,773	0	4,987,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,081,695		2,081,695		2,081,695	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	45,463,221	0	45,463,221	0	45,463,221	200.00
201.00		Less Observation Beds	2,081,695		2,081,695		2,081,695	201.00
202.00		Total (see instructions)	43,381,526	0	43,381,526	0	43,381,526	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | 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	6,196,567		6,196,567			30.00
43.00	04300	NURSERY	218,492		218,492			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,802,703	14,242,227	17,044,930	0.253477	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,045,982	0	1,045,982	0.867073	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	338,399	2,210,669	2,549,068	0.001094	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,482,481	27,613,558	29,096,039	0.129793	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
60.00	06000	LABORATORY	2,236,099	16,465,077	18,701,176	0.165408	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	332,965	4,581,259	4,914,224	0.391566	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,911	308,693	493,604	0.611020	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	60,145	169,654	229,799	0.853720	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,511,980	4,400,031	5,912,011	0.260292	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	720,363	3,153,687	3,874,050	0.375775	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	783,858	4,077,725	4,861,583	0.210617	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,183,212	26,192,102	29,375,314	0.233794	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	2,088,790	2,088,790	0.990016	0.000000	88.00
88.01	08801	RHC - N. MANCHESTER	0	1,645,804	1,645,804	1.155315	0.000000	88.01
88.02	08802	RHC - KISSINGER	0	694,647	694,647	1.220842	0.000000	88.02
90.00	09000	CLINIC	0	1,137,734	1,137,734	0.211241	0.000000	90.00
90.01	09001	SENIOR CARE	0	932,533	932,533	0.982850	0.000000	90.01
91.00	09100	EMERGENCY	957,318	22,030,133	22,987,451	0.216978	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,613,113	2,613,113	0.796634	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	22,055,475	134,557,436	156,612,911			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,055,475	134,557,436	156,612,911			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.253477		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.867073		52.00
53.00	05300	ANESTHESIOLOGY	0.001094		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129793		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.165408		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
66.00	06600	PHYSICAL THERAPY	0.391566		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.611020		67.00
68.00	06800	SPEECH PATHOLOGY	0.853720		68.00
69.00	06900	ELECTROCARDIOLOGY	0.260292		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.375775		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210617		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233794		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC - CASS ST	0.990016		88.00
88.01	08801	RHC - N. MANCHESTER	1.155315		88.01
88.02	08802	RHC - KISSINGER	1.220842		88.02
90.00	09000	CLINIC	0.211241		90.00
90.01	09001	SENIOR CARE	0.982850		90.01
91.00	09100	EMERGENCY	0.216978		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796634		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,320,502	783,561	3,536,941	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	906,943	105,800	801,143	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,789	441	2,348	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,776,463	680,363	3,096,100	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	3,093,323	396,691	2,696,632	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,924,245	156,776	1,767,469	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,602	17,358	284,244	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	196,184	11,223	184,961	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,538,847	299,146	1,239,701	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,455,772	64,160	1,391,612	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,023,930	45,127	978,803	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,867,779	501,711	6,366,068	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	2,067,936	91,139	1,976,797	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	1,901,422	83,801	1,817,621	0	0	88.01
88.02	08802	RHC - KISSINGER	848,054	37,376	810,678	0	0	88.02
90.00	09000	CLINIC	240,336	19,424	220,912	0	0	90.00
90.01	09001	SENIOR CARE	916,540	127,343	789,197	0	0	90.01
91.00	09100	EMERGENCY	4,987,773	688,622	4,299,151	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,081,695	319,455	1,762,240	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	38,452,135	4,429,517	34,022,618	0	0	200.00
201.00		Less Observation Beds	2,081,695	319,455	1,762,240	0	0	201.00
202.00		Total (line 200 minus line 201)	36,370,440	4,110,062	32,260,378	0	0	202.00

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

Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,320,502	17,044,930	0.253477		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	906,943	1,045,982	0.867073		52.00
53.00	05300	ANESTHESIOLOGY	2,789	2,549,068	0.001094		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,776,463	29,096,039	0.129793		54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
60.00	06000	LABORATORY	3,093,323	18,701,176	0.165408		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000		63.00
66.00	06600	PHYSICAL THERAPY	1,924,245	4,914,224	0.391566		66.00
67.00	06700	OCCUPATIONAL THERAPY	301,602	493,604	0.611020		67.00
68.00	06800	SPEECH PATHOLOGY	196,184	229,799	0.853720		68.00
69.00	06900	ELECTROCARDIOLOGY	1,538,847	5,912,011	0.260292		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,455,772	3,874,050	0.375775		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,023,930	4,861,583	0.210617		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,867,779	29,375,314	0.233794		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CASS ST	2,067,936	2,088,790	0.990016		88.00
88.01	08801	RHC - N. MANCHESTER	1,901,422	1,645,804	1.155315		88.01
88.02	08802	RHC - KISSINGER	848,054	694,647	1.220842		88.02
90.00	09000	CLINIC	240,336	1,137,734	0.211241		90.00
90.01	09001	SENIOR CARE	916,540	932,533	0.982850		90.01
91.00	09100	EMERGENCY	4,987,773	22,987,451	0.216978		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,081,695	2,613,113	0.796634		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	38,452,135	150,197,852			200.00
201.00		Less Observation Beds	2,081,695	0			201.00
202.00		Total (line 200 minus line 201)	36,370,440	150,197,852			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	783,561	17,044,930	0.045970	842,754	38,741	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	105,800	1,045,982	0.101149	0	0	52.00
53.00	05300	ANESTHESIOLOGY	441	2,549,068	0.000173	106,845	18	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	680,363	29,096,039	0.023383	464,660	10,865	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	396,691	18,701,176	0.021212	797,377	16,914	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	156,776	4,914,224	0.031902	156,148	4,981	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,358	493,604	0.035166	85,564	3,009	67.00
68.00	06800	SPEECH PATHOLOGY	11,223	229,799	0.048838	27,724	1,354	68.00
69.00	06900	ELECTROCARDIOLOGY	299,146	5,912,011	0.050600	792,035	40,077	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,160	3,874,050	0.016561	218,686	3,622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,127	4,861,583	0.009282	386,834	3,591	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	501,711	29,375,314	0.017079	1,171,470	20,008	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	91,139	2,088,790	0.043632	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	83,801	1,645,804	0.050918	0	0	88.01
88.02	08802	RHC - KISSINGER	37,376	694,647	0.053806	0	0	88.02
90.00	09000	CLINIC	19,424	1,137,734	0.017073	0	0	90.00
90.01	09001	SENIOR CARE	127,343	932,533	0.136556	0	0	90.01
91.00	09100	EMERGENCY	688,622	22,987,451	0.029956	42,210	1,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	319,455	2,613,113	0.122251	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,429,517	150,197,852		5,092,307	144,444	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	17,044,930	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,045,982	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,549,068	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,096,039	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	18,701,176	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,914,224	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	493,604	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	229,799	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,912,011	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,874,050	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,861,583	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	29,375,314	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	2,088,790	0.000000	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	1,645,804	0.000000	88.01
88.02	08802	RHC - KISSINGER	0	0	0	694,647	0.000000	88.02
90.00	09000	CLINIC	0	0	0	1,137,734	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	932,533	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	22,987,451	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,613,113	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	150,197,852		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	842,754	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	106,845	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	464,660	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	797,377	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.000000	156,148	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	85,564	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	27,724	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	792,035	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	218,686	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	386,834	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,171,470	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0.000000	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	0.000000	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	42,210	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,092,307	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253477	0	0	2,971,555	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.867073	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.001094	0	0	460,286	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129793	0	0	8,326,332	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.165408	0	0	4,964,224	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.391566	0	0	1,503,264	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.611020	0	0	69,410	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.853720	0	0	41,487	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260292	0	0	1,541,072	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.375775	0	0	505,600	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210617	0	0	1,033,238	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233794	0	0	12,147,695	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0.000000				0	88.00
88.01	08801	RHC - N. MANCHESTER	0.000000				0	88.01
88.02	08802	RHC - KISSINGER	0.000000				0	88.02
90.00	09000	CLINIC	0.211241	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.982850	0	0	609,678	0	90.01
91.00	09100	EMERGENCY	0.216978	0	0	4,643,285	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796634	0	0	629,824	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	39,446,950	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	39,446,950	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	753,221		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	504		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,080,700		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	821,122		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	588,627		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42,411		67.00
68.00	06800	SPEECH PATHOLOGY	0	35,418		68.00
69.00	06900	ELECTROCARDIOLOGY	0	401,129		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	189,992		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	217,617		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,840,058		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CASS ST	0	0		88.00
88.01	08801	RHC - N. MANCHESTER	0	0		88.01
88.02	08802	RHC - KISSINGER	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	599,222		90.01
91.00	09100	EMERGENCY	0	1,007,491		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	501,739		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	9,079,251		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9,079,251		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253477	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.867073	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.001094	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129793	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.165408	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.391566	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.611020	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.853720	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260292	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.375775	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210617	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233794	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0.000000				0	88.00
88.01	08801	RHC - N. MANCHESTER	0.000000				0	88.01
88.02	08802	RHC - KISSINGER	0.000000				0	88.02
90.00	09000	CLINIC	0.211241	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.982850	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.216978	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796634	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CASS ST	0	0		88.00
88.01	08801	RHC - N. MANCHESTER	0	0		88.01
88.02	08802	RHC - KISSINGER	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,048,606	0	1,048,606	4,707	222.78	30.00
43.00	NURSERY	16,026		16,026	159	100.79	43.00
200.00	Total (lines 30 through 199)	1,064,632		1,064,632	4,866		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	85	18,936	30.00
43.00	NURSERY	88	8,870	43.00
200.00	Total (lines 30 through 199)	173	27,806	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	783,561	17,044,930	0.045970	92,365	4,246	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	105,800	1,045,982	0.101149	30,802	3,116	52.00
53.00	05300	ANESTHESIOLOGY	441	2,549,068	0.000173	39,051	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	680,363	29,096,039	0.023383	64,828	1,516	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	396,691	18,701,176	0.021212	97,991	2,079	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	156,776	4,914,224	0.031902	7,268	232	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,358	493,604	0.035166	5,656	199	67.00
68.00	06800	SPEECH PATHOLOGY	11,223	229,799	0.048838	1,252	61	68.00
69.00	06900	ELECTROCARDIOLOGY	299,146	5,912,011	0.050600	29,020	1,468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,160	3,874,050	0.016561	15,743	261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,127	4,861,583	0.009282	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	501,711	29,375,314	0.017079	121,850	2,081	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	91,139	2,088,790	0.043632	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	83,801	1,645,804	0.050918	0	0	88.01
88.02	08802	RHC - KISSINGER	37,376	694,647	0.053806	0	0	88.02
90.00	09000	CLINIC	19,424	1,137,734	0.017073	0	0	90.00
90.01	09001	SENIOR CARE	127,343	932,533	0.136556	0	0	90.01
91.00	09100	EMERGENCY	688,622	22,987,451	0.029956	63,242	1,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	319,461	2,613,113	0.122253	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,429,523	150,197,852		569,068	17,160	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,707	0.00	85	30.00
43.00	04300	NURSERY		0	159	0.00	88	43.00
200.00		Total (lines 30 through 199)		0	4,866		173	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	17,044,930	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,045,982	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,549,068	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,096,039	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	18,701,176	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,914,224	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	493,604	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	229,799	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,912,011	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,874,050	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,861,583	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	29,375,314	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0	0	0	2,088,790	0.000000	88.00
88.01	08801	RHC - N. MANCHESTER	0	0	0	1,645,804	0.000000	88.01
88.02	08802	RHC - KISSINGER	0	0	0	694,647	0.000000	88.02
90.00	09000	CLINIC	0	0	0	1,137,734	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	932,533	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	22,987,451	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,613,113	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	150,197,852		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	92,365	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	30,802	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	39,051	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	64,828	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	97,991	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,268	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,656	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,252	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	29,020	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	15,743	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	121,850	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0.000000	0	0	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	0.000000	0	0	0	0	88.01
88.02	08802	RHC - KISSINGER	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	63,242	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		569,068	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | 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	0.253477	0	0	94,472	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.867073	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.001094	0	0	9,994	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129793	0	0	454,859	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.165408	0	0	347,606	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.391566	0	0	30,958	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.611020	0	0	1,476	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.853720	0	0	17,585	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260292	0	0	14,309	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.375775	0	0	41,168	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210617	0	0	2,525	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233794	0	0	510,623	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CASS ST	0.990016				0	88.00
88.01	08801	RHC - N. MANCHESTER	1.155315				0	88.01
88.02	08802	RHC - KISSINGER	1.220842				0	88.02
90.00	09000	CLINIC	0.211241	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.982850	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.216978	0	0	553,780	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796634	0	0	34,635	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	2,113,990	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	2,113,990	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | 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	23,946		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	11		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,038		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	57,497		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	12,122		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	902		67.00
68.00	06800	SPEECH PATHOLOGY	0	15,013		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,725		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,470		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	532		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	119,381		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CASS ST	0	0		88.00
88.01	08801	RHC - N. MANCHESTER	0	0		88.01
88.02	08802	RHC - KISSINGER	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	120,158		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	27,591		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	455,386		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	455,386		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,708	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,707	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)	3,273	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	1	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)	1,327	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,833,144	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)	137	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)	137	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,833,007	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,833,007	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)	1,451.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,926,366	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,926,366	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	1,195,884	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,122,250	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)	1,434	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,451.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,081,695	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,048,606	6,833,144	0.153459	2,081,695	319,455	90.00
91.00	Nursing School cost	0	6,833,144	0.000000	2,081,695	0	91.00
92.00	Allied health cost	0	6,833,144	0.000000	2,081,695	0	92.00
93.00	All other Medical Education	0	6,833,144	0.000000	2,081,695	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,708	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,707	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)	3,273	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	1	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)	85	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)	159	15.00
16.00	Nursery days (title V or XIX only)	88	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	6,833,144	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)	6,833,144	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,833,144	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)	1,451.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	123,395	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)	123,395	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	177,942	159	1,119.13	88	98,483	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)	137,836	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	359,714	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)	27,806	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,160	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	44,966	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	314,748	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)	1,434	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,451.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,081,738	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,048,606	6,833,144	0.153459	2,081,738	319,461	90.00
91.00	Nursing School cost	0	6,833,144	0.000000	2,081,738	0	91.00
92.00	Allied health cost	0	6,833,144	0.000000	2,081,738	0	92.00
93.00	All other Medical Education	0	6,833,144	0.000000	2,081,738	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,275,565		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253477	842,754	213,619	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.867073	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.001094	106,845	117	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129793	464,660	60,310	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.165408	797,377	131,893	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.391566	156,148	61,142	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.611020	85,564	52,281	67.00
68.00	06800	SPEECH PATHOLOGY	0.853720	27,724	23,669	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260292	792,035	206,160	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.375775	218,686	82,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210617	386,834	81,474	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233794	1,171,470	273,883	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CASS ST	0.000000		0	88.00
88.01	08801	RHC - N. MANCHESTER	0.000000		0	88.01
88.02	08802	RHC - KISSINGER	0.000000		0	88.02
90.00	09000	CLINIC	0.211241	0	0	90.00
90.01	09001	SENIOR CARE	0.982850	0	0	90.01
91.00	09100	EMERGENCY	0.216978	42,210	9,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796634	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,092,307	1,195,884	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)		5,092,307		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253477	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.867073	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.001094	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129793	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.165408	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.391566	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.611020	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.853720	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260292	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.375775	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210617	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233794	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CASS ST	0.000000		0	88.00
88.01	08801	RHC - N. MANCHESTER	0.000000		0	88.01
88.02	08802	RHC - KISSINGER	0.000000		0	88.02
90.00	09000	CLINIC	0.211241	0	0	90.00
90.01	09001	SENIOR CARE	0.982850	0	0	90.01
91.00	09100	EMERGENCY	0.216978	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796634	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		179,744		30.00
43.00	04300	NURSERY		13,156		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253477	92,365	23,412	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.867073	30,802	26,708	52.00
53.00	05300	ANESTHESIOLOGY	0.001094	39,051	43	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129793	64,828	8,414	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.165408	97,991	16,208	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.391566	7,268	2,846	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.611020	5,656	3,456	67.00
68.00	06800	SPEECH PATHOLOGY	0.853720	1,252	1,069	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260292	29,020	7,554	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.375775	15,743	5,916	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210617	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233794	121,850	28,488	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CASS ST	0.990016	0	0	88.00
88.01	08801	RHC - N. MANCHESTER	1.155315	0	0	88.01
88.02	08802	RHC - KISSINGER	1.220842	0	0	88.02
90.00	09000	CLINIC	0.211241	0	0	90.00
90.01	09001	SENIOR CARE	0.982850	0	0	90.01
91.00	09100	EMERGENCY	0.216978	63,242	13,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796634	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		569,068	137,836	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)		569,068		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/28/2020 4:40 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,079,251	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,079,251	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)	9,170,044	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	73,952	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,801,614	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)	2,294,478	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)	2,294,478	30.00
31.00	Primary payer payments	115	31.00
32.00	Subtotal (line 30 minus line 31)	2,294,363	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)	890,560	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	578,864	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	792,641	36.00
37.00	Subtotal (see instructions)	2,873,227	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,873,227	40.00
40.01	Sequestration adjustment (see instructions)	57,465	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,302,826	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)	-1,487,064	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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,629,766		3,750,126	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	05/29/2019	104,800	3.01
3.02			0	07/30/2019	447,900	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		552,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,629,766		4,302,826	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		69,216		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,487,064	6.02
7.00	Total Medicare program liability (see instructions)		2,698,982		2,815,762	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1310	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 7/28/2020 4:40 pm
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	0	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 7/28/2020 4:40 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,122,250	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,122,250	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,153,473	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,153,473	19.00
20.00	Deductibles (exclude professional component)	407,692	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,745,781	22.00
23.00	Coinsurance	3,069	23.00
24.00	Subtotal (line 22 minus line 23)	2,742,712	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	17,463	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,351	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,637	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,754,063	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,754,063	30.00
30.01	Sequestration adjustment (see instructions)	55,081	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,629,766	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	69,216	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 7/28/2020 4:40 pm

		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	349,849	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	21,503,508	0	0	0	4.00
5.00	Other receivable	-553,054	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,305,237	0	0	0	6.00
7.00	Inventory	880,988	0	0	0	7.00
8.00	Prepaid expenses	48,223	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-41,892,199	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-31,967,922	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,208,757	0	0	0	12.00
13.00	Land improvements	1,875,057	0	0	0	13.00
14.00	Accumulated depreciation	-321,773	0	0	0	14.00
15.00	Buildings	52,247,830	0	0	0	15.00
16.00	Accumulated depreciation	-23,120,904	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	1,962,144	0	0	0	19.00
20.00	Accumulated depreciation	-339,510	0	0	0	20.00
21.00	Automobiles and trucks	23,431	0	0	0	21.00
22.00	Accumulated depreciation	-23,431	0	0	0	22.00
23.00	Major movable equipment	12,922,283	0	0	0	23.00
24.00	Accumulated depreciation	-4,566,615	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)	41,867,269	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	318,100	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)	318,100	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,217,447	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,145,079	0	0	0	37.00
38.00	Salaries, wages, and fees payable	694,480	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,801,711	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,641,270	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,733,060	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,733,060	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30,374,330	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-20,156,883				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)	-20,156,883	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,217,447	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 7/28/2020 4:40 pm

		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		-16,106,353		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,002,704				2.00
3.00	Total (sum of line 1 and line 2)		-19,109,057		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	REMOVE HO INTEREST EXPENSE	607,735		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)		607,735		0		10.00
11.00	Subtotal (line 3 plus line 10)		-18,501,322		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS	1,655,561		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)		1,655,561		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-20,156,883		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00	REMOVE HO INTEREST EXPENSE		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	TRANSFERS		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: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/28/2020 4:40 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,071,514		6,071,514	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	580		580	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,072,094		6,072,094	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)	6,072,094		6,072,094	17.00
18.00	Ancillary services	16,711,722	0	16,711,722	18.00
19.00	Outpatient services	0	137,627,668	137,627,668	19.00
20.00	RHC - CASS ST	0	3,813,297	3,813,297	20.00
20.01	RHC - N. MANCHESTER	0	2,996,927	2,996,927	20.01
20.02	RHC - KISSINGER	0	1,550,486	1,550,486	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	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)	22,783,816	145,988,378	168,772,194	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		55,066,650		29.00
30.00	BAD DEBT	4,597,727			30.00
31.00	HOME OFFICE INTEREST EXPENSE	607,735			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)		5,205,462		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)		60,272,112		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 7/28/2020 4:40 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	168,772,194	1.00
2.00	Less contractual allowances and discounts on patients' accounts	111,991,578	2.00
3.00	Net patient revenues (line 1 minus line 2)	56,780,616	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,272,112	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,491,496	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	9,753	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	256,880	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	73,203	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	15,202	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	98,342	22.00
23.00	Governmental appropriations	0	23.00
24.00	GAIN ON DISPOSAL OF ASSETS	1,776	24.00
24.01	OTHER	0	24.01
24.02	MISC	7,510	24.02
24.03	RHC INTERUNIT RENT	26,126	24.03
25.00	Total other income (sum of lines 6-24)	488,792	25.00
26.00	Total (line 5 plus line 25)	-3,002,704	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)	-3,002,704	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8544 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC I

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	91,899	0	91,899	0	91,899	1.00
2.00	Physician Assistant	329,135	0	329,135	-162,780	166,355	2.00
3.00	Nurse Practitioner	0	0	0	162,780	162,780	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	187,351	0	187,351	0	187,351	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	37,550	0	37,550	0	37,550	9.00
10.00	Subtotal (sum of lines 1 through 9)	645,935	0	645,935	0	645,935	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	109,329	109,329	0	109,329	15.00
16.00	Transportation (Health Care Staff)	0	1,061	1,061	0	1,061	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	8,481	8,481	0	8,481	18.00
19.00	Other Health Care Costs	0	6,854	6,854	0	6,854	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	125,725	125,725	0	125,725	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	645,935	125,725	771,660	0	771,660	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	201,782	201,782	0	201,782	29.00
30.00	Administrative Costs	307,990	222,728	530,718	0	530,718	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	307,990	424,510	732,500	0	732,500	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	953,925	550,235	1,504,160	0	1,504,160	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8544 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	91,899		1.00
2.00	Physician Assistant	0	166,355		2.00
3.00	Nurse Practitioner	0	162,780		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	187,351		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	37,550		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	645,935		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	109,329		15.00
16.00	Transportation (Health Care Staff)	0	1,061		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	8,481		18.00
19.00	Other Health Care Costs	0	6,854		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	125,725		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	771,660		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-22,510	179,272		29.00
30.00	Administrative Costs	0	530,718		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-22,510	709,990		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-22,510	1,481,650		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC II

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	318,965	0	318,965	1,358	320,323	1.00
2.00	Physician Assistant	84,921	0	84,921	-44,705	40,216	2.00
3.00	Nurse Practitioner	0	0	0	43,347	43,347	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	175,170	0	175,170	0	175,170	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	13,046	0	13,046	0	13,046	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	592,102	0	592,102	0	592,102	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	187,763	187,763	0	187,763	15.00
16.00	Transportation (Health Care Staff)	0	3,158	3,158	0	3,158	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	13,058	13,058	0	13,058	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	203,979	203,979	0	203,979	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	592,102	203,979	796,081	0	796,081	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	135,662	135,662	0	135,662	29.00
30.00	Administrative Costs	365,064	93,664	458,728	0	458,728	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	365,064	229,326	594,390	0	594,390	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	957,166	433,305	1,390,471	0	1,390,471	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	320,323		1.00
2.00	Physician Assistant	0	40,216		2.00
3.00	Nurse Practitioner	0	43,347		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	175,170		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	13,046		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	592,102		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	187,763		15.00
16.00	Transportation (Health Care Staff)	0	3,158		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	13,058		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	203,979		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	796,081		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-28,910	106,752		29.00
30.00	Administrative Costs	784	459,512		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-28,126	566,264		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-28,126	1,362,345		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC III

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	4,736	0	4,736	0	4,736	1.00
2.00	Physician Assistant	133,089	0	133,089	0	133,089	2.00
3.00	Nurse Practitioner	50,138	0	50,138	0	50,138	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	54,766	0	54,766	0	54,766	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	242,729	0	242,729	0	242,729	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	60,595	60,595	0	60,595	15.00
16.00	Transportation (Health Care Staff)	0	3,436	3,436	0	3,436	16.00
17.00	Depreciation-Medical Equipment	0	3,752	3,752	0	3,752	17.00
18.00	Professional Liability Insurance	0	6,518	6,518	0	6,518	18.00
19.00	Other Health Care Costs	0	671	671	0	671	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	74,972	74,972	0	74,972	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	242,729	74,972	317,701	0	317,701	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	82,543	82,543	0	82,543	29.00
30.00	Administrative Costs	116,236	91,170	207,406	0	207,406	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	116,236	173,713	289,949	0	289,949	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	358,965	248,685	607,650	0	607,650	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	4,736		1.00
2.00	Physician Assistant	0	133,089		2.00
3.00	Nurse Practitioner	0	50,138		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	54,766		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	242,729		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	60,595		15.00
16.00	Transportation (Health Care Staff)	0	3,436		16.00
17.00	Depreciation-Medical Equipment	0	3,752		17.00
18.00	Professional Liability Insurance	0	6,518		18.00
19.00	Other Health Care Costs	0	671		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	74,972		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	317,701		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	82,543		29.00
30.00	Administrative Costs	-30	207,376		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-30	289,919		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-30	607,620		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1310 | Component CCN: 15-8544 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC I

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.32	1,192	4,200	1,344		1.00
2.00	Physician Assistant	0.00	146	2,100	0		2.00
3.00	Nurse Practitioner	3.21	10,882	2,100	6,741		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.53	12,220		8,085	12,220	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.53	12,220			12,220	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					771,660	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					771,660	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					709,990	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					586,286	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,296,276	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,296,276	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,296,276	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,067,936	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC II

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.22	4,337	4,200	5,124		1.00
2.00	Physician Assistant	0.37	1,045	2,100	777		2.00
3.00	Nurse Practitioner	0.62	1,783	2,100	1,302		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.21	7,165		7,203	7,203	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.21	7,165			7,203	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					796,081	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					796,081	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					566,264	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					539,077	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,105,341	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,105,341	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,105,341	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,901,422	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 7/28/2020 4:40 pm

RHC III

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.71	2,020	4,200	2,982		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.55	1,290	2,100	1,155		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.26	3,310		4,137	4,137	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.26	3,310			4,137	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					317,701	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					317,701	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					289,919	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					240,434	15.00
16.00	Total overhead (sum of lines 14 and 15)					530,353	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					530,353	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					530,353	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					848,054	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1310 Component CCN: 15-8544	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 7/28/2020 4:40 pm
	Title XVIII	RHC I	

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	2,067,936	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	122,294	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,945,642	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	12,220	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	12,220	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	159.22	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	159.22	159.22	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,781	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	283,571	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	283,571	16.00
16.01	Total program charges (see instructions)(from contractor's records)		262,904	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,360	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,467	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		220,331	16.04
16.05	Total program cost (see instructions)	0	221,798	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,690	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		50,971	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		221,798	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		37,933	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		259,731	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		259,731	26.00
26.01	Sequestration adjustment (see instructions)		5,195	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		371,949	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-117,413	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1310 Component CCN: 15-8541	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 7/28/2020 4:40 pm
	Title XVIII	RHC II	

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	1,901,422	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	178,553	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,722,869	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	7,203	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	7,203	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	239.19	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	239.19	239.19	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,637	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	391,554	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	391,554	16.00
16.01	Total program charges (see instructions)(from contractor's records)		398,537	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		123,366	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		121,204	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		212,634	16.04
16.05	Total program cost (see instructions)	0	333,838	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,558	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		54,123	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		333,838	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		39,772	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		373,610	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		373,610	26.00
26.01	Sequestration adjustment (see instructions)		7,472	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		309,867	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		56,271	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1310 Component CCN: 15-8542	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 7/28/2020 4:40 pm
	Title XVIII	RHC III	

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	848,054	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	95,509	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	752,545	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	4,137	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	4,137	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	181.91	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	181.91	181.91	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,006	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	183,001	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	183,001	16.00
16.01	Total program charges (see instructions)(from contractor's records)		214,100	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		50,718	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		43,351	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		109,064	16.04
16.05	Total program cost (see instructions)	0	152,415	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,320	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		32,012	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		152,415	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		38,573	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		190,988	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		190,988	26.00
26.01	Sequestration adjustment (see instructions)		3,820	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		134,144	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		53,024	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1310 Component CCN: 15-8544	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 7/28/2020 4:40 pm
	Title XVIII	RHC I	

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	645,935	645,935	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000520	0.003302	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	336	2,133	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	16,640	26,526	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	16,976	28,659	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	771,660	771,660	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,296,276	1,296,276	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.021999	0.037139	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	28,517	48,142	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	45,493	76,801	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	136	863	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	334.51	88.99	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	57	212	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	19,067	18,866	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		122,294	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		37,933	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1310 Component CCN: 15-8541	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 7/28/2020 4:40 pm
	Title XVIII	RHC II	

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	592,102	592,102	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001533	0.005204	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	908	3,081	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	39,332	31,435	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	40,240	34,516	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	796,081	796,081	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,105,341	1,105,341	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.050548	0.043357	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	55,873	47,924	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	96,113	82,440	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	292	991	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	329.15	83.19	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	67	213	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	22,053	17,719	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		178,553	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		39,772	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-4 | Date/Time Prepared: 7/28/2020 4:40 pm

Title XVIII | RHC III

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	242,729	242,729	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001334	0.006774	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	324	1,644	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	13,201	20,611	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	13,525	22,255	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	317,701	317,701	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	530,353	530,353	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.042571	0.070050	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	22,578	37,151	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	36,103	59,406	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	104	528	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	347.14	112.51	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	45	204	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	15,621	22,952	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		95,509	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		38,573	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1310 Component CCN: 15-8544	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 7/28/2020 4:40 pm
		RHC I	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		371,949	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		371,949	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			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		117,413	6.02
7.00	Total Medicare program liability (see instructions)		254,536	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1310 Component CCN: 15-8541	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 7/28/2020 4:40 pm
		RHC II	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		309,867	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		309,867	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			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		56,271	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		366,138	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1310 Component CCN: 15-8542	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 7/28/2020 4:40 pm
		RHC III	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		134,144	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		134,144	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			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		53,024	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		187,168	7.00

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