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: 15-3030	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/17/2020 2:35 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/17/2020 Time: 2:35 pm
2. [ ] Manually submitted 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 REHABILITATION HOSPITAL OF FT WAYNE (15-3030) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
Officer or Administrator of Provider(s)

VP, REVENUE MANAGEMENT
Title

Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-100,558	0	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
200.00	Total	0	-100,558	0	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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2020 2:35 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 7970 WEST JEFFERSON BOULEVARD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46804-	County: ALLEN	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	REHABILITATION HOSPITAL OF FT WAYNE	153030	23060	5	11/01/1993	N	P	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2018	09/30/2019	20.00
21.00	Type of Control (see instructions)	4		21.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2020 2:35 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	
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.	248	0	0	0	719		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/17/2020 2:35 pm

		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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/17/2020 2:35 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.	Y			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)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3030	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/17/2020 2:35 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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/17/2020 2:35 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	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	7,579	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.	N		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	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			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	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2020 2:35 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: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	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)		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II | Date/Time Prepared: 2/17/2020 2:35 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/14/2020	Y	01/14/2020	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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 2/17/2020 2:35 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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	N		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.	Y	12/31/2018	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.	CALEB	TUBBS	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7183	CALEB_TUBBS@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3030	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/17/2020 2:35 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.	MANAGER, REVENUE MANAGEMENT		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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 2/17/2020 2:35 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	36	13,140	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	13,140	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		36	13,140	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		36				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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 2/17/2020 2:35 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)	4,425	248	9,139			1.00
2.00	HMO and other (see instructions)	1,356	719				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,425	248	9,139			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)	4,425	248	9,139	0.00	110.15	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	110.15	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 2/17/2020 2:35 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	356	65	695	1.00
2.00	HMO and other (see instructions)			92	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	356	65	695	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part IV Date/Time Prepared: 2/17/2020 2:35 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	125,508	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	560,080	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	2,342	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,121	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	42	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	3,563	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	60,492	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	434,105	17.00
18.00	Medicare Taxes - Employers Portion Only	101,525	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	23,667	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,316,445	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/17/2020 2:35 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		327,447	327,447	179,016	506,463	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		163,873	163,873	67,527	231,400	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	189,106	45,392	234,498	772,613	1,007,111	4.00
5.01	00570	ADMITTING	88,583	131,860	220,443	-180	220,263	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	906,217	1,844,333	2,750,550	-1,261,657	1,488,893	5.02
7.00	00700	OPERATION OF PLANT	248,678	546,819	795,497	61,669	857,166	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,217	45,217	0	45,217	8.00
9.00	00900	HOUSEKEEPING	127,020	33,267	160,287	-3,567	156,720	9.00
10.00	01000	DIETARY	397,325	266,950	664,275	-151,045	513,230	10.00
11.00	01100	CAFETERIA	0	0	0	140,088	140,088	11.00
13.00	01300	NURSING ADMINISTRATION	544,103	94,934	639,037	-459	638,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,420	76,458	81,878	-68,783	13,095	14.00
15.00	01500	PHARMACY	122,431	308,968	431,399	-295,829	135,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,715	72,762	232,477	-2,803	229,674	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,715,073	1,201,223	3,916,296	294,477	4,210,773	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,030	4,030	0	4,030	54.00
60.00	06000	LABORATORY	31,276	33,928	65,204	-729	64,475	60.00
65.00	06500	RESPIRATORY THERAPY	14,075	18,300	32,375	-11,650	20,725	65.00
66.00	06600	PHYSICAL THERAPY	671,143	78,140	749,283	-12,148	737,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	692,461	66,058	758,519	-306	758,213	67.00
68.00	06800	SPEECH PATHOLOGY	319,662	29,948	349,610	-815	348,795	68.00
69.00	06900	ELECTROCARDIOLOGY	0	81	81	0	81	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,707	16,707	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	278,465	278,465	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	102,977	12,549	115,526	-28	115,498	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	163,704	163,704	0	163,704	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,335,265	5,566,241	12,901,506	563	12,902,069	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	143	3,611	3,754	-563	3,191	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	7,335,408	5,569,852	12,905,260	0	12,905,260	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/17/2020 2:35 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	-92,147	414,316		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,593	242,993		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,007,111		4.00
5.01	00570	ADMITTING	-46,044	174,219		5.01
5.02	00590	ADMIN AND GENERAL - OTHER	37,173	1,526,066		5.02
7.00	00700	OPERATION OF PLANT	-6,460	850,706		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,217		8.00
9.00	00900	HOUSEKEEPING	0	156,720		9.00
10.00	01000	DIETARY	0	513,230		10.00
11.00	01100	CAFETERIA	-93,168	46,920		11.00
13.00	01300	NURSING ADMINISTRATION	0	638,578		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,095		14.00
15.00	01500	PHARMACY	0	135,570		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	229,674		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-297,639	3,913,134		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,030		54.00
60.00	06000	LABORATORY	0	64,475		60.00
65.00	06500	RESPIRATORY THERAPY	0	20,725		65.00
66.00	06600	PHYSICAL THERAPY	0	737,135		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	758,213		67.00
68.00	06800	SPEECH PATHOLOGY	0	348,795		68.00
69.00	06900	ELECTROCARDIOLOGY	0	81		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,707		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	278,465		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	115,498		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	163,704		76.01
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-486,692	12,415,377		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,191		192.00
194.00	07950	NON-REIMBURSABLE COST	0	0		194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0		194.01
194.02	07952	TENANT LEASED SPACE	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-486,692	12,418,568		200.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/17/2020 2:35 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	772,905	1.00
2.00		0.00	0	0	2.00
	0		0	772,905	
	B - RENTAL AND LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,117	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	67,527	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	0		0	73,644	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,895	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	158,004	2.00
	0		0	172,899	
	D - REPAIRS & MAINTENANCE COSTS				
1.00	OPERATION OF PLANT	7.00	0	64,333	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	64,333	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16,707	1.00
2.00		0.00	0	0	2.00
	0		0	16,707	
	F - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	278,465	1.00
	0		0	278,465	
	G - PHYSICIAN DIRECTORS				
1.00	ADULTS & PEDIATRICS	30.00	0	297,552	1.00
	0		0	297,552	
	H - DIETARY				
1.00	CAFETERIA	11.00	81,785	58,303	1.00
	0		81,785	58,303	
500.00	Grand Total: Increases		81,785	1,734,808	500.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/17/2020 2:35 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMIN AND GENERAL - OTHER	5.02	0	772,901	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4	0		2.00
	0		0	772,905			
	B - RENTAL AND LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	292	10		1.00
2.00	ADMITTING	5.01	0	180	10		2.00
3.00	ADMIN AND GENERAL - OTHER	5.02	0	2,826	0		3.00
4.00	OPERATION OF PLANT	7.00	0	2,664	0		4.00
5.00	DIETARY	10.00	0	619	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	24	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	41,071	0		7.00
8.00	PHARMACY	15.00	0	9,924	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,803	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	1,525	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	10,855	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	730	0		12.00
13.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	28	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	103	0		14.00
	0		0	73,644			
	C - OTHER CAPITAL COSTS						
1.00	ADMIN AND GENERAL - OTHER	5.02	0	172,899	12		1.00
2.00		0.00	0	0	13		2.00
	0		0	172,899			
	D - REPAIRS & MAINTENANCE COSTS						
1.00	ADMIN AND GENERAL - OTHER	5.02	0	15,479	0		1.00
2.00	HOUSEKEEPING	9.00	0	3,567	0		2.00
3.00	DIETARY	10.00	0	10,338	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	435	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,010	0		5.00
6.00	PHARMACY	15.00	0	7,440	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	1,550	0		7.00
8.00	LABORATORY	60.00	0	729	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	795	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	11,418	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	301	0		11.00
12.00	SPEECH PATHOLOGY	68.00	0	815	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	456	0		13.00
	0		0	64,333			
	E - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,702	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	0	5	0		2.00
	0		0	16,707			
	F - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	278,465	0		1.00
	0		0	278,465			
	G - PHYSICIAN DIRECTORS						
1.00	ADMIN AND GENERAL - OTHER	5.02	0	297,552	0		1.00
	0		0	297,552			
	H - DIETARY						
1.00	DIETARY	10.00	81,785	58,303	0		1.00
	0		81,785	58,303			
500.00	Grand Total: Decreases		81,785	1,734,808			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part I | Date/Time Prepared: 2/17/2020 2:35 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	900,000	0	0	0	0	1.00
2.00	Land Improvements	288,293	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,897,568	140,082	0	140,082	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1,198,306	42,424	0	42,424	4,549	6.00
7.00	HIT designated Assets	7,715	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,291,882	182,506	0	182,506	4,549	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,291,882	182,506	0	182,506	4,549	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	900,000	0	1.00
2.00	Land Improvements	288,293	0	2.00
3.00	Buildings and Fixtures	12,037,650	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	1,236,181	0	6.00
7.00	HIT designated Assets	7,715	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,469,839	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,469,839	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part II | Date/Time Prepared: 2/17/2020 2:35 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	327,447	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	163,873	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	491,320	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	327,447	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	163,873	2.00
3.00	Total (sum of lines 1-2)	0	491,320	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 2/17/2020 2:35 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,225,943	0	13,225,943	0.914035	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,243,895	0	1,243,895	0.085965	0	2.00
3.00	Total (sum of lines 1-2)	14,469,838	0	14,469,838	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	192,411	6,117	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	175,466	67,527	2.00
3.00	Total (sum of lines 1-2)	0	0	0	367,877	73,644	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	42,889	14,895	158,004	0	414,316	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	242,993	2.00
3.00	Total (sum of lines 1-2)	42,889	14,895	158,004	0	657,309	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/17/2020 2:35 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		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-297,639			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	528,028			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-93,168	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-8,893	CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,852	ADMIN AND GENERAL - OTHER	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-132,509	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-22,561	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
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	MISCELANEOUS INCOME	B	-1,266	ADMIN AND GENERAL - OTHER	5.02	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/17/2020 2:35 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	
33.01	MARKETING EXPENSE	A	-437,484	ADMIN AND GENERAL - OTHER	5.02	0	33.01
33.02	PATIENT TELEPHONE EXPENSE	A	-7,494	ADMIN AND GENERAL - OTHER	5.02	0	33.02
33.03	PATIENT TV CABLE EXPENSE	A	-6,460	OPERATION OF PLANT	7.00	0	33.03
33.04	PHYSICIAN RECRUITING EXPENSE	A	-4,210	ADMIN AND GENERAL - OTHER	5.02	0	33.04
33.05	LOBBYING FEES SXPENSE	A	-637	ADMIN AND GENERAL - OTHER	5.02	0	33.05
33.06	CHARITABLE CONTRIBUTIONS	A	-547	ADMIN AND GENERAL - OTHER	5.02	0	33.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-486,692				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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 2/17/2020 2:35 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	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	42,889	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	127	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	13	0	4.02
4.03	5.01	ADMITTING	PASI Operating Costs	1,391	6,179	4.03
4.04	5.02	ADMIN AND GENERAL - OTHER	Shared Service Center Alloca	216,904	58,856	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	6,239	0	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	34,141	0	4.06
4.07	5.02	ADMIN AND GENERAL - OTHER	Non-Capital Home Office Cost	411,028	0	4.07
4.08	5.02	ADMIN AND GENERAL - OTHER	Malpractice Costs	7,579	85,992	4.08
4.09	5.01	ADMITTING	HIIM Allocation	0	41,256	4.09
4.10	0.00		PASI Lien Unit Collection Fe	0	0	4.10
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			720,311	192,283	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:					
6.00	B		0.00	COMMUNITY HEALT	100.00	6.00
7.00	B		0.00	LUTHERAN	100.00	7.00
8.00	G	HOSPITAL LAUNDR	100.00	LAUNDRY	100.00	8.00
9.00	B		0.00	PASI	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				100.00

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.

(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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 2/17/2020 2:35 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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	42,889	11		4.00
4.01	127	9		4.01
4.02	13	9		4.02
4.03	-4,788	0		4.03
4.04	158,048	0		4.04
4.05	6,239	9		4.05
4.06	34,141	9		4.06
4.07	411,028	0		4.07
4.08	-78,413	0		4.08
4.09	-41,256	0		4.09
4.10	0	0		4.10
5.00	528,028			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	HOSPITAL		7.00
8.00	CONSOL LAUNDRY		8.00
9.00	DEBT COLLECTION		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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 2/17/2020 2:35 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	30.00	ADULTS & PEDIATRICS	297,639	297,639	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			297,639	297,639	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	297,639		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	297,639		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	414,316	414,316				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	242,993		242,993			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,007,111	1,671	1,207	1,009,989		4.00
5.01	00570	ADMITTING	174,219	8,609	6,217	12,519	201,564	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	1,526,066	32,608	23,549	128,076	0	5.02
7.00	00700	OPERATION OF PLANT	850,706	75,898	54,815	35,146	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,217	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	156,720	8,200	5,922	17,952	0	9.00
10.00	01000	DIETARY	513,230	0	0	44,595	0	10.00
11.00	01100	CAFETERIA	46,920	31,680	22,879	11,559	0	11.00
13.00	01300	NURSING ADMINISTRATION	638,578	887	640	76,898	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,095	6,262	4,523	766	0	14.00
15.00	01500	PHARMACY	135,570	2,654	1,916	17,303	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	229,674	3,042	2,197	22,573	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,971	1,424	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,913,134	52,752	38,098	383,722	78,076	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,030	2,933	2,118	0	1,907	54.00
60.00	06000	LABORATORY	64,475	0	0	4,420	7,793	60.00
65.00	06500	RESPIRATORY THERAPY	20,725	682	493	1,989	237	65.00
66.00	06600	PHYSICAL THERAPY	737,135	68,838	49,715	94,853	29,750	66.00
67.00	06700	OCCUPATIONAL THERAPY	758,213	32,499	23,471	97,866	30,228	67.00
68.00	06800	SPEECH PATHOLOGY	348,795	2,463	1,779	45,178	12,285	68.00
69.00	06900	ELECTROCARDIOLOGY	81	0	0	0	27	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,707	0	0	0	1,282	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	278,465	0	0	0	32,085	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	115,498	2,811	2,030	14,554	4,221	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	163,704	0	0	0	3,673	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,415,377	336,460	242,993	1,009,969	201,564	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,191	0	0	20	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	77,856	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,418,568	414,316	242,993	1,009,989	201,564	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	Subtotal	ADMIN AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER	1,710,299	1,710,299				5.02
7.00	00700	OPERATION OF PLANT	1,016,565	162,364	1,178,929			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,217	7,222	0	52,439		8.00
9.00	00900	HOUSEKEEPING	188,794	30,154	32,710	0	251,658	9.00
10.00	01000	DIETARY	557,825	89,095	0	0	0	10.00
11.00	01100	CAFETERIA	113,038	18,054	126,378	0	38,060	11.00
13.00	01300	NURSING ADMINISTRATION	717,003	114,518	3,538	0	1,065	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,646	3,936	24,982	0	7,523	14.00
15.00	01500	PHARMACY	157,443	25,146	10,586	0	3,188	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	257,486	41,125	12,137	0	3,655	16.00
17.00	01700	SOCIAL SERVICE	3,395	542	7,865	0	2,368	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,465,782	713,264	210,439	29,415	63,375	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,988	1,755	11,702	0	3,524	54.00
60.00	06000	LABORATORY	76,688	12,248	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	24,126	3,853	2,721	0	820	65.00
66.00	06600	PHYSICAL THERAPY	980,291	156,570	274,608	10,919	82,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	942,277	150,499	129,644	12,105	39,043	67.00
68.00	06800	SPEECH PATHOLOGY	410,500	65,564	9,824	0	2,959	68.00
69.00	06900	ELECTROCARDIOLOGY	108	17	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,989	2,873	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,550	49,600	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	139,114	22,219	11,212	0	3,377	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	167,377	26,733	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,337,501	1,697,351	868,346	52,439	251,658	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,211	513	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	77,856	12,435	310,583	0	0	194.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,418,568	1,710,299	1,178,929	52,439	251,658	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	646,920					10.00
11.00	01100	CAFETERIA	0	295,530				11.00
13.00	01300	NURSING ADMINISTRATION	0	25,935	862,059			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	544	0	61,631		14.00
15.00	01500	PHARMACY	0	4,853	0	0	201,216	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,037	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	646,920	172,457	862,059	48,679	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	3,960	0	24	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	854	0	1,831	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,448	0	2,410	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	31,486	0	2,348	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,074	0	134	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	4,834	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	201,216	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,882	0	1,358	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	646,920	295,530	862,059	61,618	201,216	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	13	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	646,920	295,530	862,059	61,631	201,216	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	322,440					16.00
17.00	01700	SOCIAL SERVICE	0	14,170				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	124,894	14,170	7,351,454	0	7,351,454	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,051	0	31,020	0	31,020	54.00
60.00	06000	LABORATORY	12,466	0	105,386	0	105,386	60.00
65.00	06500	RESPIRATORY THERAPY	379	0	34,584	0	34,584	65.00
66.00	06600	PHYSICAL THERAPY	47,592	0	1,586,539	0	1,586,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,355	0	1,355,757	0	1,355,757	67.00
68.00	06800	SPEECH PATHOLOGY	19,653	0	520,708	0	520,708	68.00
69.00	06900	ELECTROCARDIOLOGY	44	0	169	0	169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,050	0	27,746	0	27,746	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,327	0	612,693	0	612,693	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,753	0	187,915	0	187,915	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	5,876	0	199,986	0	199,986	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	322,440	14,170	12,013,957	0	12,013,957	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,737	0	3,737	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	400,874	0	400,874	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	322,440	14,170	12,418,568	0	12,418,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/17/2020 2:35 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	1,671	1,207	2,878	2,878	4.00
5.01	00570	ADMITTING	0	8,609	6,217	14,826	36	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	0	32,608	23,549	56,157	365	5.02
7.00	00700	OPERATION OF PLANT	0	75,898	54,815	130,713	100	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,200	5,922	14,122	51	9.00
10.00	01000	DIETARY	0	0	0	0	127	10.00
11.00	01100	CAFETERIA	0	31,680	22,879	54,559	33	11.00
13.00	01300	NURSING ADMINISTRATION	0	887	640	1,527	219	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,262	4,523	10,785	2	14.00
15.00	01500	PHARMACY	0	2,654	1,916	4,570	49	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,042	2,197	5,239	64	16.00
17.00	01700	SOCIAL SERVICE	0	1,971	1,424	3,395	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	52,752	38,098	90,850	1,094	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,933	2,118	5,051	0	54.00
60.00	06000	LABORATORY	0	0	0	0	13	60.00
65.00	06500	RESPIRATORY THERAPY	0	682	493	1,175	6	65.00
66.00	06600	PHYSICAL THERAPY	0	68,838	49,715	118,553	270	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	32,499	23,471	55,970	279	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,463	1,779	4,242	129	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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,811	2,030	4,841	41	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	336,460	242,993	579,453	2,878	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	77,856	0	77,856	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	414,316	242,993	657,309	2,878	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	ADMITTING	ADMIN AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	14,862					5.01
5.02	00590	ADMIN AND GENERAL - OTHER	0	56,522				5.02
7.00	00700	OPERATION OF PLANT	0	5,365	136,178			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	239	0	239		8.00
9.00	00900	HOUSEKEEPING	0	996	3,778	0	18,947	9.00
10.00	01000	DIETARY	0	2,944	0	0	0	10.00
11.00	01100	CAFETERIA	0	597	14,598	0	2,865	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,784	409	0	80	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	130	2,886	0	566	14.00
15.00	01500	PHARMACY	0	831	1,223	0	240	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,359	1,402	0	275	16.00
17.00	01700	SOCIAL SERVICE	0	18	908	0	178	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,756	23,575	24,308	134	4,771	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	141	58	1,352	0	265	54.00
60.00	06000	LABORATORY	575	405	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	17	127	314	0	62	65.00
66.00	06600	PHYSICAL THERAPY	2,194	5,174	31,720	50	6,228	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,229	4,973	14,975	55	2,940	67.00
68.00	06800	SPEECH PATHOLOGY	906	2,167	1,135	0	223	68.00
69.00	06900	ELECTROCARDIOLOGY	2	1	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94	95	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,366	1,639	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	311	734	1,295	0	254	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	271	883	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,862	56,094	100,303	239	18,947	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	411	35,875	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,862	56,522	136,178	239	18,947	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	3,071					10.00
11.00	01100	CAFETERIA	0	72,652				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,376	12,395			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	134	0	14,503		14.00
15.00	01500	PHARMACY	0	1,193	0	0	8,106	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,976	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,071	42,395	12,395	11,455	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	974	0	6	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	210	0	431	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,731	0	567	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,741	0	553	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,968	0	31	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	1,137	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,106	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	954	0	320	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,071	72,652	12,395	14,500	8,106	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	3	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,071	72,652	12,395	14,503	8,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	10,315					16.00
17.00	01700	SOCIAL SERVICE	0	4,499				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,984	4,499	228,287	0	228,287	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	98	0	6,965	0	6,965	54.00
60.00	06000	LABORATORY	400	0	2,373	0	2,373	60.00
65.00	06500	RESPIRATORY THERAPY	12	0	2,354	0	2,354	65.00
66.00	06600	PHYSICAL THERAPY	1,525	0	174,012	0	174,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,550	0	91,265	0	91,265	67.00
68.00	06800	SPEECH PATHOLOGY	630	0	12,431	0	12,431	68.00
69.00	06900	ELECTROCARDIOLOGY	1	0	4	0	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66	0	1,392	0	1,392	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,645	0	13,756	0	13,756	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	216	0	8,966	0	8,966	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	188	0	1,342	0	1,342	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,315	4,499	543,147	0	543,147	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	20	0	20	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	114,142	0	114,142	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,315	4,499	657,309	0	657,309	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	728,820					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		591,864				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,940	2,940	7,146,302			4.00
5.01	00570	ADMITTING	15,144	15,144	88,583	43,970,831		5.01
5.02	00590	ADMIN AND GENERAL - OTHER	57,360	57,360	906,217	0	-1,710,299	5.02
7.00	00700	OPERATION OF PLANT	133,512	133,512	248,678	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	14,424	14,424	127,020	0	0	9.00
10.00	01000	DIETARY	0	0	315,540	0	0	10.00
11.00	01100	CAFETERIA	55,728	55,728	81,785	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,560	1,560	544,103	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,016	11,016	5,420	0	0	14.00
15.00	01500	PHARMACY	4,668	4,668	122,431	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,352	5,352	159,715	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,468	3,468	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,796	92,796	2,715,073	17,031,580	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,160	5,160	0	416,061	0	54.00
60.00	06000	LABORATORY	0	0	31,276	1,700,019	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,200	1,200	14,075	51,740	0	65.00
66.00	06600	PHYSICAL THERAPY	121,092	121,092	671,143	6,490,070	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,168	57,168	692,461	6,594,204	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,332	4,332	319,662	2,680,082	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,945	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	279,568	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,999,440	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,944	4,944	102,977	920,864	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	801,258	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	591,864	591,864	7,146,159	43,970,831	-1,710,299	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	143	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	136,956	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	414,316	242,993	1,009,989	201,564		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.568475	0.410555	0.141330	0.004584		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,878	14,862		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000403	0.000338		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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	ADMIN AND GENERAL - OTHER (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUN)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER	10,708,269					5.02
7.00	00700	OPERATION OF PLANT	1,016,565	519,864				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,217	0	88,579			8.00
9.00	00900	HOUSEKEEPING	188,794	14,424	0	368,484		9.00
10.00	01000	DIETARY	557,825	0	0	0	55,138	10.00
11.00	01100	CAFETERIA	113,038	55,728	0	55,728	0	11.00
13.00	01300	NURSING ADMINISTRATION	717,003	1,560	0	1,560	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,646	11,016	0	11,016	0	14.00
15.00	01500	PHARMACY	157,443	4,668	0	4,668	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	257,486	5,352	0	5,352	0	16.00
17.00	01700	SOCIAL SERVICE	3,395	3,468	0	3,468	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,465,782	92,796	49,686	92,796	55,138	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,988	5,160	0	5,160	0	54.00
60.00	06000	LABORATORY	76,688	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	24,126	1,200	0	1,200	0	65.00
66.00	06600	PHYSICAL THERAPY	980,291	121,092	18,445	121,092	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	942,277	57,168	20,448	57,168	0	67.00
68.00	06800	SPEECH PATHOLOGY	410,500	4,332	0	4,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	108	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,989	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,550	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	139,114	4,944	0	4,944	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	167,377	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,627,202	382,908	88,579	368,484	55,138	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,211	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	77,856	136,956	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,710,299	1,178,929	52,439	251,658	646,920	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.159718	2.267764	0.592003	0.682955	11.732743	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56,522	136,178	239	18,947	3,071	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005278	0.261949	0.002698	0.051419	0.055697	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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES-NURS AREAS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	7,612					11.00
13.00	01300	NURSING ADMINISTRATION	668	2,026,528				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14	0	211,491			14.00
15.00	01500	PHARMACY	125	0	0	278,465		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207	0	0	0	43,970,831	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,442	2,026,528	167,047	0	17,031,580	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	416,061	54.00
60.00	06000	LABORATORY	102	0	83	0	1,700,019	60.00
65.00	06500	RESPIRATORY THERAPY	22	0	6,282	0	51,740	65.00
66.00	06600	PHYSICAL THERAPY	810	0	8,271	0	6,490,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	811	0	8,059	0	6,594,204	67.00
68.00	06800	SPEECH PATHOLOGY	311	0	459	0	2,680,082	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	5,945	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,587	0	279,568	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	278,465	6,999,440	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	100	0	4,660	0	920,864	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	801,258	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,612	2,026,528	211,448	278,465	43,970,831	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	43	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	295,530	862,059	61,631	201,216	322,440	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.824225	0.425387	0.291412	0.722590	0.007333	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	72,652	12,395	14,503	8,106	10,315	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.544404	0.006116	0.068575	0.029110	0.000235	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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/17/2020 2:35 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS %)		
			17.00		
		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
5.01	00570	ADMITTING			5.01
5.02	00590	ADMIN AND GENERAL - OTHER			5.02
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
17.00	01700	SOCIAL SERVICE	9,139		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	9,139		30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0		76.01
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,139		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	NON-REIMBURSABLE COST	0		194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0		194.01
194.02	07952	TENANT LEASED SPACE	0		194.02
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	14,170		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.550498		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,499		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.492286		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | 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	7,351,454		7,351,454	0	7,351,454	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,020		31,020	0	31,020	54.00
60.00	06000	LABORATORY	105,386		105,386	0	105,386	60.00
65.00	06500	RESPIRATORY THERAPY	34,584	0	34,584	0	34,584	65.00
66.00	06600	PHYSICAL THERAPY	1,586,539	0	1,586,539	0	1,586,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,355,757	0	1,355,757	0	1,355,757	67.00
68.00	06800	SPEECH PATHOLOGY	520,708	0	520,708	0	520,708	68.00
69.00	06900	ELECTROCARDIOLOGY	169		169	0	169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,746		27,746	0	27,746	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	612,693		612,693	0	612,693	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	187,915		187,915	0	187,915	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	199,986		199,986	0	199,986	76.01
200.00		Subtotal (see instructions)	12,013,957	0	12,013,957	0	12,013,957	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	12,013,957	0	12,013,957	0	12,013,957	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/17/2020 2:35 pm

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		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	17,031,580		17,031,580			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	416,061	0	416,061	0.074556	0.000000	54.00
60.00	06000	LABORATORY	1,699,757	262	1,700,019	0.061991	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	51,740	0	51,740	0.668419	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,490,070	0	6,490,070	0.244456	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,586,269	7,935	6,594,204	0.205598	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,680,082	0	2,680,082	0.194288	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,945	0	5,945	0.028427	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	267,116	12,452	279,568	0.099246	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,999,440	0	6,999,440	0.087535	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	920,864	0	920,864	0.204064	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	801,258	0	801,258	0.249590	0.000000	76.01
200.00		Subtotal (see instructions)	43,950,182	20,649	43,970,831			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43,950,182	20,649	43,970,831			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074556	54.00
60.00	06000	LABORATORY	0.061991	60.00
65.00	06500	RESPIRATORY THERAPY	0.668419	65.00
66.00	06600	PHYSICAL THERAPY	0.244456	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.205598	67.00
68.00	06800	SPEECH PATHOLOGY	0.194288	68.00
69.00	06900	ELECTROCARDIOLOGY	0.028427	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099246	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.087535	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.204064	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.249590	76.01
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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/17/2020 2:35 pm

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		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	7,351,454		7,351,454	0	7,351,454	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,020		31,020	0	31,020	54.00
60.00	06000	LABORATORY	105,386		105,386	0	105,386	60.00
65.00	06500	RESPIRATORY THERAPY	34,584	0	34,584	0	34,584	65.00
66.00	06600	PHYSICAL THERAPY	1,586,539	0	1,586,539	0	1,586,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,355,757	0	1,355,757	0	1,355,757	67.00
68.00	06800	SPEECH PATHOLOGY	520,708	0	520,708	0	520,708	68.00
69.00	06900	ELECTROCARDIOLOGY	169		169	0	169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,746		27,746	0	27,746	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	612,693		612,693	0	612,693	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	187,915		187,915	0	187,915	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	199,986		199,986	0	199,986	76.01
200.00		Subtotal (see instructions)	12,013,957	0	12,013,957	0	12,013,957	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	12,013,957	0	12,013,957	0	12,013,957	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/17/2020 2:35 pm

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		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	17,031,580		17,031,580			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	416,061	0	416,061	0.074556	0.000000	54.00
60.00	06000	LABORATORY	1,699,757	262	1,700,019	0.061991	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	51,740	0	51,740	0.668419	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,490,070	0	6,490,070	0.244456	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,586,269	7,935	6,594,204	0.205598	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,680,082	0	2,680,082	0.194288	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,945	0	5,945	0.028427	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	267,116	12,452	279,568	0.099246	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,999,440	0	6,999,440	0.087535	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	920,864	0	920,864	0.204064	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	801,258	0	801,258	0.249590	0.000000	76.01
200.00		Subtotal (see instructions)	43,950,182	20,649	43,970,831			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43,950,182	20,649	43,970,831			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/17/2020 2:35 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
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074556		54.00
60.00	06000	LABORATORY	0.061991		60.00
65.00	06500	RESPIRATORY THERAPY	0.668419		65.00
66.00	06600	PHYSICAL THERAPY	0.244456		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.205598		67.00
68.00	06800	SPEECH PATHOLOGY	0.194288		68.00
69.00	06900	ELECTROCARDIOLOGY	0.028427		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099246		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.087535		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.204064		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.249590		76.01
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: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part II Date/Time Prepared: 2/17/2020 2:35 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,020	6,965	24,055	0	0	54.00
60.00	06000	LABORATORY	105,386	2,373	103,013	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	34,584	2,354	32,230	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,586,539	174,012	1,412,527	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,355,757	91,265	1,264,492	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	520,708	12,431	508,277	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	169	4	165	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,746	1,392	26,354	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	612,693	13,756	598,937	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	187,915	8,966	178,949	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	199,986	1,342	198,644	0	0	76.01
200.00		Subtotal (sum of lines 50 thru 199)	4,662,503	314,860	4,347,643	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	4,662,503	314,860	4,347,643	0	0	202.00

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

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part II Date/Time Prepared: 2/17/2020 2:35 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					
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,020	416,061	0.074556		54.00
60.00	06000	LABORATORY	105,386	1,700,019	0.061991		60.00
65.00	06500	RESPIRATORY THERAPY	34,584	51,740	0.668419		65.00
66.00	06600	PHYSICAL THERAPY	1,586,539	6,490,070	0.244456		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,355,757	6,594,204	0.205598		67.00
68.00	06800	SPEECH PATHOLOGY	520,708	2,680,082	0.194288		68.00
69.00	06900	ELECTROCARDIOLOGY	169	5,945	0.028427		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,746	279,568	0.099246		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	612,693	6,999,440	0.087535		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	187,915	920,864	0.204064		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	199,986	801,258	0.249590		76.01
200.00		Subtotal (sum of lines 50 thru 199)	4,662,503	26,939,251			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	4,662,503	26,939,251			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part I Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	228,287	0	228,287	9,139	24.98	30.00
200.00	Total (lines 30 through 199)	228,287		228,287	9,139		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	4,425	110,537	30.00
200.00	Total (lines 30 through 199)	4,425	110,537	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part II Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,965	416,061	0.016740	298,484	4,997	54.00
60.00	06000	LABORATORY	2,373	1,700,019	0.001396	908,622	1,268	60.00
65.00	06500	RESPIRATORY THERAPY	2,354	51,740	0.045497	21,038	957	65.00
66.00	06600	PHYSICAL THERAPY	174,012	6,490,070	0.026812	3,201,120	85,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,265	6,594,204	0.013840	3,235,156	44,775	67.00
68.00	06800	SPEECH PATHOLOGY	12,431	2,680,082	0.004638	1,144,683	5,309	68.00
69.00	06900	ELECTROCARDIOLOGY	4	5,945	0.000673	2,232	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,392	279,568	0.004979	139,710	696	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,756	6,999,440	0.001965	3,591,609	7,058	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,966	920,864	0.009737	450,345	4,385	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	1,342	801,258	0.001675	467,406	783	76.01
200.00		Total (lines 50 through 199)	314,860	26,939,251		13,460,405	156,058	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part III Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	9,139	0.00	4,425	30.00
200.00		Total (lines 30 through 199)		0	9,139		4,425	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	416,061	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,700,019	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	51,740	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,490,070	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,594,204	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,680,082	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,945	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	279,568	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,999,440	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	920,864	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	801,258	0.000000	76.01
200.00		Total (lines 50 through 199)	0	0	0	26,939,251		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	298,484	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	908,622	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	21,038	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,201,120	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,235,156	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,144,683	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,232	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	139,710	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,591,609	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	450,345	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.000000	467,406	0	0	0	76.01
200.00		Total (lines 50 through 199)		13,460,405	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part I Date/Time Prepared: 2/17/2020 2:35 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	228,287	0	228,287	9,139	24.98	30.00
200.00	Total (lines 30 through 199)	228,287		228,287	9,139		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	248	6,195	30.00
200.00	Total (lines 30 through 199)	248	6,195	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part II Date/Time Prepared: 2/17/2020 2:35 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,965	416,061	0.016740	14,213	238	54.00
60.00	06000	LABORATORY	2,373	1,700,019	0.001396	41,386	58	60.00
65.00	06500	RESPIRATORY THERAPY	2,354	51,740	0.045497	613	28	65.00
66.00	06600	PHYSICAL THERAPY	174,012	6,490,070	0.026812	160,332	4,299	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,265	6,594,204	0.013840	162,870	2,254	67.00
68.00	06800	SPEECH PATHOLOGY	12,431	2,680,082	0.004638	54,646	253	68.00
69.00	06900	ELECTROCARDIOLOGY	4	5,945	0.000673	279	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,392	279,568	0.004979	3,032	15	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,756	6,999,440	0.001965	282,790	556	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,966	920,864	0.009737	23,006	224	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	1,342	801,258	0.001675	56,601	95	76.01
200.00		Total (lines 50 through 199)	314,860	26,939,251		799,768	8,020	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part III Date/Time Prepared: 2/17/2020 2:35 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
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	9,139	0.00	248	30.00
200.00		Total (lines 30 through 199)		0	9,139		248	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/17/2020 2:35 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 2/17/2020 2:35 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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	416,061	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,700,019	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	51,740	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,490,070	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,594,204	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,680,082	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,945	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	279,568	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,999,440	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	920,864	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	801,258	0.000000	76.01
200.00		Total (lines 50 through 199)	0	0	0	26,939,251		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/17/2020 2:35 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	14,213	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	41,386	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	613	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	160,332	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	162,870	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	54,646	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	279	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,032	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	282,790	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	23,006	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.000000	56,601	0	0	0	76.01
200.00		Total (lines 50 through 199)		799,768	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,139	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,139	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)	9,139	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,425	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,351,454	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)	7,351,454	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)	7,351,454	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)	804.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,559,470	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,559,470	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,299,594	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,859,064	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)	110,537	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	156,058	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	266,595	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,592,469	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	228,287	7,351,454	0.031053	0	0	90.00
91.00	Nursing School cost	0	7,351,454	0.000000	0	0	91.00
92.00	Allied health cost	0	7,351,454	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,351,454	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/17/2020 2:35 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)	9,139	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,139	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)	9,139	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	248	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,351,454	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)	7,351,454	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)	7,351,454	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)	804.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	199,491	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)	199,491	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/17/2020 2:35 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)						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)	131,218	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	330,709	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)	6,195	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,020	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	14,215	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	316,494	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/17/2020 2:35 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	228,287	7,351,454	0.031053	0	0	90.00
91.00	Nursing School cost	0	7,351,454	0.000000	0	0	91.00
92.00	Allied health cost	0	7,351,454	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,351,454	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		8,255,030		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074556	298,484	22,254	54.00
60.00	06000	LABORATORY	0.061991	908,622	56,326	60.00
65.00	06500	RESPIRATORY THERAPY	0.668419	21,038	14,062	65.00
66.00	06600	PHYSICAL THERAPY	0.244456	3,201,120	782,533	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.205598	3,235,156	665,142	67.00
68.00	06800	SPEECH PATHOLOGY	0.194288	1,144,683	222,398	68.00
69.00	06900	ELECTROCARDIOLOGY	0.028427	2,232	63	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099246	139,710	13,866	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.087535	3,591,609	314,391	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.204064	450,345	91,899	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.249590	467,406	116,660	76.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,460,405	2,299,594	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)		13,460,405		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/17/2020 2:35 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		390,159		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074556	14,213	1,060	54.00
60.00	06000	LABORATORY	0.061991	41,386	2,566	60.00
65.00	06500	RESPIRATORY THERAPY	0.668419	613	410	65.00
66.00	06600	PHYSICAL THERAPY	0.244456	160,332	39,194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.205598	162,870	33,486	67.00
68.00	06800	SPEECH PATHOLOGY	0.194288	54,646	10,617	68.00
69.00	06900	ELECTROCARDIOLOGY	0.028427	279	8	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099246	3,032	301	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.087535	282,790	24,754	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.204064	23,006	4,695	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.249590	56,601	14,127	76.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		799,768	131,218	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)		799,768		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 2/17/2020 2:35 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,691,789		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)		6,691,789		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		100,558		0	6.02
7.00	Total Medicare program liability (see instructions)		6,591,231		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: 15-3030	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/17/2020 2:35 pm
	Title XVIII	Hospital	PPS

			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	Provider CCN: 15-3030	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part III Date/Time Prepared: 2/17/2020 2:35 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	6,455,331	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0193	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	246,594	3.00
4.00	Outlier Payments	117,558	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	25.038356	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	6,819,483	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	6,819,483	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	6,819,483	19.00
20.00	Deductibles	63,724	20.00
21.00	Subtotal (line 19 minus line 20)	6,755,759	21.00
22.00	Coinsurance	30,013	22.00
23.00	Subtotal (line 21 minus line 22)	6,725,746	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	6,725,746	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	6,725,746	32.00
32.01	Sequestration adjustment (see instructions)	134,515	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	6,691,789	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-100,558	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	26,467	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	117,558	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3030	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/17/2020 2:35 pm
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	390,159		8.00
9.00	Ancillary service charges	799,768	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,189,927	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,189,927	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,189,927	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G | Date/Time Prepared: 2/17/2020 2:35 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	-17,414	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	3,187,040	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-232,353	0	0	0	6.00
7.00	Inventory	9,520	0	0	0	7.00
8.00	Prepaid expenses	66,854	0	0	0	8.00
9.00	Other current assets	570	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,014,217	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	900,000	0	0	0	12.00
13.00	Land improvements	288,293	0	0	0	13.00
14.00	Accumulated depreciation	-165,150	0	0	0	14.00
15.00	Buildings	11,662,532	0	0	0	15.00
16.00	Accumulated depreciation	-3,040,377	0	0	0	16.00
17.00	Leasehold improvements	889,676	0	0	0	17.00
18.00	Accumulated depreciation	-198,755	0	0	0	18.00
19.00	Fixed equipment	609,905	0	0	0	19.00
20.00	Accumulated depreciation	-148,129	0	0	0	20.00
21.00	Automobiles and trucks	113,428	0	0	0	21.00
22.00	Accumulated depreciation	-113,428	0	0	0	22.00
23.00	Major movable equipment	630,878	0	0	0	23.00
24.00	Accumulated depreciation	-246,364	0	0	0	24.00
25.00	Minor equipment depreciable	378,946	0	0	0	25.00
26.00	Accumulated depreciation	-284,000	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)	11,277,455	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	572,149	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	572,149	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,863,821	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	290,225	0	0	0	37.00
38.00	Salaries, wages, and fees payable	591,199	0	0	0	38.00
39.00	Payroll taxes payable	75,030	0	0	0	39.00
40.00	Notes and loans payable (short term)	12,300	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	18,753,227	0	0	0	43.00
44.00	Other current liabilities	197,078	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,919,059	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,919,059	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-5,055,238				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)	-5,055,238	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,863,821	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-1 | Date/Time Prepared: 2/17/2020 2:35 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		-5,093,311		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		38,074				2.00
3.00	Total (sum of line 1 and line 2)		-5,055,237		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-5,055,237		0		11.00
12.00	ROUNDING DISCREPANCY	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-5,055,238		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING DISCREPANCY		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/17/2020 2:35 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	17,031,580		17,031,580	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	17,031,580		17,031,580	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)	17,031,580		17,031,580	17.00
18.00	Ancillary services	26,918,602	20,649	26,939,251	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	43,950,182	20,649	43,970,831	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,905,260		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		12,905,260		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-3 | Date/Time Prepared: 2/17/2020 2:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,970,831	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,131,295	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,839,536	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,905,260	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-65,724	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	103,798	24.00
25.00	Total other income (sum of lines 6-24)	103,798	25.00
26.00	Total (line 5 plus line 25)	38,074	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)	38,074	29.00