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: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/26/2020 12:31 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/26/2020 Time: 12:31 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (15-1304) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	122,808	-627,432	0	153,238	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	29,828	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC (RHC) I	0		0		0	10.00
200.00	Total	0	152,636	-627,432	0	153,238	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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/26/2020 12:31 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 NORTH MAIN STREET	PO Box:			1.00
2.00	City: RUSHVILLE	State: IN	Zip Code: 46173-	County: RUSH	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	RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	RUSH SWING BEDS	15Z304	99915		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	RMH HEALTHCARE ASSOC	158539	99915		06/12/2019	N	O	O	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			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.	0			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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 12:31 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.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 12:31 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: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 12:31 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 12:31 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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	135,109	0	0	118.01

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 8/26/2020 12:31 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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	02/18/2020	Y	02/18/2020	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: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/26/2020 12:31 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	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.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LANDON	HACKETT	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7929	LHACKETT@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/26/2020 12:31 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.	SENIOR MANAGER		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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 8/26/2020 12:31 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	25	9,125	30,768.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	30,768.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	30,768.00	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 (RHC)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/26/2020 12:31 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)	871	53	1,282			1.00
2.00	HMO and other (see instructions)	31	10				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	56	0	56			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	47			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	927	53	1,385			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)	927	53	1,385	0.00	271.00	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 (RHC)	0	0	2,622	0.00	5.12	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	276.12	27.00
28.00	Observation Bed Days		0	587			28.00
29.00	Ambulance Trips	194					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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 8/26/2020 12:31 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	267	20	403	1.00
2.00	HMO and other (see instructions)			8	7		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	267	20	403	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 (RHC)	0.00					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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 8/26/2020 12:31 pm

RHC I | Cost

			1.00	
	Clinic Address and Identification			
1.00	Street		201 CONRAD HARCOURT WAY	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	RUSHVILLE	IN	46173	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:00	08:00	11.00

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

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

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	RUSH	2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	05:00	08:00	05:00	08:00	05:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2019 To 12/31/2019	Worksheet S-8 Date/Time Prepared: 8/26/2020 12:31 pm
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 8/26/2020 12:31 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.347509	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,393,186	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	12,086,235	6.00
7.00	Medicaid cost (line 1 times line 6)	4,200,075	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,806,889	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,806,889	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	123,612	0	123,612	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	42,956	0	42,956	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	42,956	0	42,956	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,159,362	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,031,006	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,586,163	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,573,199	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,449,367	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,492,323	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,299,212	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/26/2020 12:31 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	NEW CAP REL COSTS-BLDG & FIXT		2,265,015	2,265,015	0	2,265,015	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	374,042	4,714,141	5,088,183	6,841	5,095,024	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,757,190	7,717,440	10,474,630	-143,047	10,331,583	5.00
7.00	00700	OPERATION OF PLANT	296,793	748,550	1,045,343	27,485	1,072,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,158	97,158	0	97,158	8.00
9.00	00900	HOUSEKEEPING	380,838	138,297	519,135	27,485	546,620	9.00
10.00	01000	DIETARY	350,983	155,793	506,776	-351,762	155,014	10.00
11.00	01100	CAFETERIA	0	0	0	379,247	379,247	11.00
13.00	01300	NURSING ADMINISTRATION	115,710	2,000	117,710	0	117,710	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,348	65,767	135,115	11,213	146,328	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	344,631	66,467	411,098	0	411,098	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,790,948	87,678	1,878,626	-727,160	1,151,466	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,065,484	547,562	1,613,046	-370,448	1,242,598	50.00
51.00	05100	RECOVERY ROOM	0	13,197	13,197	31,236	44,433	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,061,193	627,757	1,688,950	52	1,689,002	54.00
54.01	05401	ONCOLOGY	462,400	171,531	633,931	-8,026	625,905	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	635,719	846,459	1,482,178	-119	1,482,059	60.00
65.00	06500	RESPIRATORY THERAPY	92,398	24,692	117,090	-13,811	103,279	65.00
66.00	06600	PHYSICAL THERAPY	279,795	7,974	287,769	34,037	321,806	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,330	1,866	194,196	34,028	228,224	67.00
68.00	06800	SPEECH PATHOLOGY	156,302	2,555	158,857	-68,152	90,705	68.00
69.00	06900	ELECTROCARDIOLOGY	122,190	3,497	125,687	-299	125,388	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	444,075	444,075	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	165,447	165,447	0	165,447	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560,202	4,622,732	5,182,934	-3,541	5,179,393	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	1,517,289	93,901	1,611,190	-307,251	1,303,939	88.00
90.00	09000	CLINIC	792,630	58,595	851,225	1,065,738	1,916,963	90.00
90.01	09001	SURGICAL ASSOCIATES	54,013	555,050	609,063	-660	608,403	90.01
90.02	09002	ORTHOPAEDICS	33,093	140,033	173,126	0	173,126	90.02
90.03	09003	RHEUMATOLOGY	520,745	10,364	531,109	-321	530,788	90.03
90.04	09004	SPECIALTY CLINIC	387,195	234,912	622,107	-30,090	592,017	90.04
90.05	09005	PEDIATRICS	378,825	10,462	389,287	-12	389,275	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	491,617	7,655	499,272	-362	498,910	90.07
90.08	09008	ONCOLOGY MD	0	283,077	283,077	0	283,077	90.08
91.00	09100	EMERGENCY	1,009,986	1,243,131	2,253,117	-35,838	2,217,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	74,332	24,771	99,103	-538	98,565	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,368,221	25,755,526	42,123,747	0	42,123,747	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	62,401	6	62,407	0	62,407	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	16,430,622	25,755,532	42,186,154	0	42,186,154	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-167,689	2,097,326	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-247,187	4,847,837	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,085,080	4,246,503	5.00
7.00	00700	OPERATION OF PLANT	-89	1,072,739	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,158	8.00
9.00	00900	HOUSEKEEPING	-463	546,157	9.00
10.00	01000	DIETARY	-1,717	153,297	10.00
11.00	01100	CAFETERIA	-174,795	204,452	11.00
13.00	01300	NURSING ADMINISTRATION	-1,030	116,680	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	146,328	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,200	409,898	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	1,151,466	30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-725,146	517,452	50.00
51.00	05100	RECOVERY ROOM	0	44,433	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-704,416	984,586	54.00
54.01	05401	ONCOLOGY	-103,200	522,705	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	-1,477	1,480,582	60.00
65.00	06500	RESPIRATORY THERAPY	0	103,279	65.00
66.00	06600	PHYSICAL THERAPY	0	321,806	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	228,224	67.00
68.00	06800	SPEECH PATHOLOGY	0	90,705	68.00
69.00	06900	ELECTROCARDIOLOGY	-21	125,367	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-8,177	435,898	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	165,447	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-55,338	5,124,055	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	1,303,939	88.00
90.00	09000	CLINIC	-1,523,726	393,237	90.00
90.01	09001	SURGICAL ASSOCIATES	-542,677	65,726	90.01
90.02	09002	ORTHOPAEDICS	-166,910	6,216	90.02
90.03	09003	RHEUMATOLOGY	-595,252	-64,464	90.03
90.04	09004	SPECIALTY CLINIC	-499,776	92,241	90.04
90.05	09005	PEDIATRICS	-324,394	64,881	90.05
90.06	09006	WOMEN'S HEALTH	0	0	90.06
90.07	09007	PAIN MANAGEMENT	-495,645	3,265	90.07
90.08	09008	ONCOLOGY MD	-270,577	12,500	90.08
91.00	09100	EMERGENCY	0	2,217,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-3,840	94,725	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,699,822	29,423,925	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	62,407	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,699,822	29,486,332	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - DIETARY/ CAFETERIA				
1.00	CAFETERIA	11.00	262,659	116,588	1.00
	0		262,659	116,588	
	C - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	444,075	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,213	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	455,288	
	E - SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6,871	0	1.00
2.00	OPERATION OF PLANT	7.00	27,485	0	2.00
3.00	HOUSEKEEPING	9.00	27,485	0	3.00
4.00	DIETARY	10.00	27,485	0	4.00
5.00	RECOVERY ROOM	51.00	38,327	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	4,440	0	6.00
7.00	PHYSICAL THERAPY	66.00	34,076	0	7.00
8.00	OCCUPATIONAL THERAPY	67.00	34,076	0	8.00
9.00	CLINIC	90.00	27,485	0	9.00
10.00	EMERGENCY	91.00	4,440	0	10.00
	0		232,170	0	
	F - PHYSICIAN RECLASS				
1.00	CLINIC	90.00	314,427	0	1.00
2.00	RURAL HEALTH CLINIC (RHC)	88.00	394,004	0	2.00
	0		708,431	0	
	G - PHYSICIAN PRACTICE ADMIN RECLASS				
1.00	CLINIC	90.00	11,645	0	1.00
2.00	RURAL HEALTH CLINIC (RHC)	88.00	14,592	0	2.00
	TOTALS		26,237	0	
	H - RHC RECLASS				
1.00	CLINIC	90.00	673,427	41,677	1.00
	TOTALS		673,427	41,677	
500.00	Grand Total: Increases		1,902,924	613,553	500.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	B - DIETARY/ CAFETERIA					
1.00	DIETARY	10.00	262,659	116,588	0	1.00
	0		262,659	116,588		
	C - MED SUPPLY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	30	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18,729	0	2.00
3.00	OPERATING ROOM	50.00	0	336,561	0	3.00
4.00	RECOVERY ROOM	51.00	0	7,091	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,388	0	5.00
6.00	ONCOLOGY	54.01	0	8,026	0	6.00
7.00	LABORATORY	60.00	0	119	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	490	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	39	0	9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	48	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	299	0	11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,541	0	12.00
13.00	RURAL HEALTH CLINIC (RHC)	88.00	0	743	0	13.00
14.00	CLINIC	90.00	0	2,923	0	14.00
15.00	SURGICAL ASSOCIATES	90.01	0	660	0	15.00
16.00	RHEUMATOLOGY	90.03	0	321	0	16.00
17.00	SPECIALTY CLINIC	90.04	0	30,090	0	17.00
18.00	PEDIATRICS	90.05	0	12	0	18.00
19.00	PAIN MANAGEMENT	90.07	0	362	0	19.00
20.00	EMERGENCY	91.00	0	40,278	0	20.00
21.00	AMBULANCE SERVICES	95.00	0	538	0	21.00
	0		0	455,288		
	E - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	116,810	0	0	1.00
2.00	OPERATING ROOM	50.00	33,887	0	0	2.00
3.00	RESPIRATORY THERAPY	65.00	13,321	0	0	3.00
4.00	SPEECH PATHOLOGY	68.00	68,152	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
	0		232,170	0		
	F - PHYSICIAN RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	708,431	0	0	1.00
2.00		0.00	0	0	0	2.00
	0		708,431	0		
	G - PHYSICIAN PRACTICE ADMIN RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	26,237	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		26,237	0		
	H - RHC RECLASS					
1.00	RURAL HEALTH CLINIC (RHC)	88.00	673,427	41,677	0	1.00
	TOTALS		673,427	41,677		
500.00	Grand Total: Decreases		1,902,924	613,553		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 8/26/2020 12:31 pm

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	188,708	0	0	0	0	1.00
2.00	Land Improvements	455,968	20,680	0	20,680	0	2.00
3.00	Buildings and Fixtures	18,469,048	252,421	0	252,421	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,748,328	1,697,987	0	1,697,987	859,421	5.00
6.00	Movable Equipment	16,365,047	762,141	0	762,141	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,227,099	2,733,229	0	2,733,229	859,421	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,227,099	2,733,229	0	2,733,229	859,421	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	188,708	0	1.00
2.00	Land Improvements	476,648	0	2.00
3.00	Buildings and Fixtures	18,721,469	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,586,894	0	5.00
6.00	Movable Equipment	17,127,188	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,100,907	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	39,100,907	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II Date/Time Prepared: 8/26/2020 12:31 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	NEW CAP REL COSTS-BLDG & FIXT	1,809,551	0	192,996	262,468	0	1.00
3.00	Total (sum of lines 1-2)	1,809,551	0	192,996	262,468	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,265,015	1.00
3.00	Total (sum of lines 1-2)	0	2,265,015	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III | Date/Time Prepared: 8/26/2020 12:31 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	NEW CAP REL COSTS-BLDG & FIXT	39,100,907	0	39,100,907	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	39,100,907	0	39,100,907	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,797,611	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,797,611	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	37,247	262,468	0	0	2,097,326	1.00
3.00	Total (sum of lines 1-2)	37,247	262,468	0	0	2,097,326	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/26/2020 12:31 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,799,580			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-11,940	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/26/2020 12:31 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	
33.00	CAFETERIA	B	-96,252	CAFETERIA	11.00	0	33.00
33.01	JAIL MEALS	B	-78,543	CAFETERIA	11.00	0	33.01
33.02	VENDING MACHINES	B	-532	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	SALE OF DRUGS	B	-9,595	DRUGS CHARGED TO PATIENTS	73.00	0	33.03
33.04	SALE OF SUPPLIES	B	-33	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.04
33.05	SALE OF PODIATRY SUPPLIES	B	-8,144	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.05
33.06	PHYSICIAN APPLICATION FEES	B	-4,400	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	NSF FEES	B	-931	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	MEDICAL RECORDS TRANSCRIPTION FEES	B	-1,200	MEDICAL RECORDS & LIBRARY	16.00	0	33.08
33.09	COPIER FEES	B	-3,823	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ATHLETIC TRAINER - SCHOOL REV	B	-9,025	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OCCUPATIONAL HEALTH	B	-100,330	CLINIC	90.00	0	33.11
33.12	SALE OF SCRAP	B	-749	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	SHUTTLE BUS SERVICES	B	-3,840	AMBULANCE SERVICES	95.00	0	33.13
33.14	MISC. INCOME	B	-2,519	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	MISC. INCOME	B	-49,476	RHEUMATOLOGY	90.03	0	33.15
33.16	INTEREST INCOME	B	-155,749	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.16
33.17	TELEPHONE SALARY	A	-5,340	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	TELEPHONE OTHER	A	-1,206	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	TELEPHONE BENEFITS	A	-847	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	ADVERTISING	A	-246,256	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	IHA & AHA LOBBYING	A	-3,718	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	REBATES	B	-7,984	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	REBATES	B	-89	OPERATION OF PLANT	7.00	0	33.23
33.24	REBATES	B	-463	HOUSEKEEPING	9.00	0	33.24
33.25	REBATES	B	-1,717	DIETARY	10.00	0	33.25
33.26	REBATES	B	-1,030	NURSING ADMINISTRATION	13.00	0	33.26
33.27	REBATES	B	-1,002	OPERATING ROOM	50.00	0	33.27
33.28	REBATES	B	-1,331	RADIOLOGY-DIAGNOSTIC	54.00	0	33.28
33.29	REBATES	B	-1,477	LABORATORY	60.00	0	33.29
33.30	REBATES	B	-21	ELECTROCARDIOLOGY	69.00	0	33.30
33.31	REBATES	B	-45,743	DRUGS CHARGED TO PATIENTS	73.00	0	33.31
33.32	HAF EXPENSE	A	-1,500,150	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	PHYSICIAN RECRUITMENTS	A	-91,382	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	BAD DEBTS	A	-4,453,405	ADMINISTRATIVE & GENERAL	5.00	0	33.34
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,699,822				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 8/26/2020 12:31 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	50.00	OPERATING ROOM	749,084	724,144	24,940	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	727,252	703,085	24,167	0	0	2.00
3.00	54.01	ONCOLOGY	103,200	103,200	0	0	0	3.00
4.00	60.00	LABORATORY	38,400	0	38,400	0	0	4.00
5.00	90.00	CLINIC	1,481,076	1,423,396	57,680	0	0	5.00
6.00	90.01	SURGICAL ASSOCIATES	550,000	542,677	7,323	0	0	6.00
7.00	90.02	ORTHOPAEDICS	168,380	166,910	1,470	0	0	7.00
8.00	90.03	RHEUMATOLOGY	563,071	545,776	17,295	0	0	8.00
9.00	90.04	SPECIALTY CLINIC	534,428	499,776	34,652	0	0	9.00
10.00	90.05	PEDIATRICS	336,435	324,394	12,041	0	0	10.00
11.00	90.07	PAIN MANAGEMENT	518,199	495,645	22,554	0	0	11.00
12.00	90.08	ONCOLOGY MD	283,077	270,577	12,500	0	0	12.00
13.00	91.00	EMERGENCY	1,140,515	0	1,140,515	0	0	13.00
200.00			7,193,117	5,799,580	1,393,537		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	54.01	ONCOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	SURGICAL ASSOCIATES	0	0	0	0	0	6.00
7.00	90.02	ORTHOPAEDICS	0	0	0	0	0	7.00
8.00	90.03	RHEUMATOLOGY	0	0	0	0	0	8.00
9.00	90.04	SPECIALTY CLINIC	0	0	0	0	0	9.00
10.00	90.05	PEDIATRICS	0	0	0	0	0	10.00
11.00	90.07	PAIN MANAGEMENT	0	0	0	0	0	11.00
12.00	90.08	ONCOLOGY MD	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
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	50.00	OPERATING ROOM	0	0	0	724,144		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	703,085		2.00
3.00	54.01	ONCOLOGY	0	0	0	103,200		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	90.00	CLINIC	0	0	0	1,423,396		5.00
6.00	90.01	SURGICAL ASSOCIATES	0	0	0	542,677		6.00
7.00	90.02	ORTHOPAEDICS	0	0	0	166,910		7.00
8.00	90.03	RHEUMATOLOGY	0	0	0	545,776		8.00
9.00	90.04	SPECIALTY CLINIC	0	0	0	499,776		9.00
10.00	90.05	PEDIATRICS	0	0	0	324,394		10.00
11.00	90.07	PAIN MANAGEMENT	0	0	0	495,645		11.00
12.00	90.08	ONCOLOGY MD	0	0	0	270,577		12.00
13.00	91.00	EMERGENCY	0	0	0	0		13.00
200.00			0	0	0	5,799,580		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,097,326	2,097,326				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,847,837	15,478	4,863,315			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,246,503	294,338	792,121	5,332,962	5,332,962	5.00
7.00	00700	OPERATION OF PLANT	1,072,739	155,778	98,261	1,326,778	292,947	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,158	15,315	0	112,473	24,834	8.00
9.00	00900	HOUSEKEEPING	546,157	37,184	123,728	707,069	156,118	9.00
10.00	01000	DIETARY	153,297	64,677	35,092	253,066	55,876	10.00
11.00	01100	CAFETERIA	204,452	21,497	79,590	305,539	67,462	11.00
13.00	01300	NURSING ADMINISTRATION	116,680	14,293	35,062	166,035	36,660	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	146,328	45,946	21,014	213,288	47,093	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	409,898	30,398	104,429	544,725	120,273	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,151,466	152,757	328,020	1,632,243	360,393	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	517,452	126,147	312,590	956,189	211,123	50.00
51.00	05100	RECOVERY ROOM	44,433	14,595	11,614	70,642	15,597	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	984,586	143,856	322,904	1,451,346	320,451	54.00
54.01	05401	ONCOLOGY	522,705	51,244	140,115	714,064	157,662	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,480,582	48,642	192,633	1,721,857	380,179	60.00
65.00	06500	RESPIRATORY THERAPY	103,279	3,044	23,962	130,285	28,766	65.00
66.00	06600	PHYSICAL THERAPY	321,806	50,710	95,108	467,624	103,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	228,224	20,056	68,605	316,885	69,967	67.00
68.00	06800	SPEECH PATHOLOGY	90,705	4,206	26,711	121,622	26,854	68.00
69.00	06900	ELECTROCARDIOLOGY	125,367	9,343	37,026	171,736	37,919	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	435,898	0	0	435,898	96,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	165,447	0	0	165,447	36,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,124,055	39,415	169,750	5,333,220	1,177,547	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	1,303,939	94,796	379,515	1,778,250	392,630	88.00
90.00	09000	CLINIC	393,237	276,441	551,372	1,221,050	269,603	90.00
90.01	09001	SURGICAL ASSOCIATES	65,726	36,487	16,367	118,580	26,182	90.01
90.02	09002	ORTHOPAEDICS	6,216	25,053	10,028	41,297	9,118	90.02
90.03	09003	RHEUMATOLOGY	-64,464	33,443	157,794	126,773	27,991	90.03
90.04	09004	SPECIALTY CLINIC	92,241	8,366	117,326	217,933	48,119	90.04
90.05	09005	PEDIATRICS	64,881	67,768	114,790	247,439	54,634	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	3,265	0	148,968	152,233	33,612	90.07
90.08	09008	ONCOLOGY MD	12,500	0	0	12,500	2,760	90.08
91.00	09100	EMERGENCY	2,217,279	89,660	307,387	2,614,326	577,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	94,725	86,639	22,524	203,888	45,018	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,423,925	2,077,572	4,844,406	29,385,262	5,310,646	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	62,407	19,754	18,909	101,070	22,316	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,486,332	2,097,326	4,863,315	29,486,332	5,332,962	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,619,725					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,203	152,510				8.00
9.00	00900	HOUSEKEEPING	36,910	10,704	910,801			9.00
10.00	01000	DIETARY	64,201	4,389	37,302	414,834		10.00
11.00	01100	CAFETERIA	21,339	0	12,398	0	406,738	11.00
13.00	01300	NURSING ADMINISTRATION	14,187	0	8,243	0	2,194	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,608	0	26,499	0	4,607	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,174	0	17,532	0	23,913	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	151,633	99,442	88,101	414,834	39,928	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	125,219	9,982	72,754	0	23,693	50.00
51.00	05100	RECOVERY ROOM	14,487	0	8,417	0	1,755	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142,797	6,449	82,967	0	28,520	54.00
54.01	05401	ONCOLOGY	50,867	0	29,554	0	18,867	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	48,284	0	28,053	0	30,714	60.00
65.00	06500	RESPIRATORY THERAPY	3,022	1,285	1,756	0	3,510	65.00
66.00	06600	PHYSICAL THERAPY	50,337	3,003	29,246	0	11,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,909	1,381	11,567	0	6,362	67.00
68.00	06800	SPEECH PATHOLOGY	4,176	59	2,426	0	2,633	68.00
69.00	06900	ELECTROCARDIOLOGY	9,274	0	5,388	0	5,046	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,125	0	22,732	0	16,015	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	94,099	0	54,672	0	34,663	88.00
90.00	09000	CLINIC	274,408	0	159,435	0	62,084	90.00
90.01	09001	SURGICAL ASSOCIATES	36,218	0	21,043	0	4,168	90.01
90.02	09002	ORTHOPAEDICS	24,868	0	14,449	0	219	90.02
90.03	09003	RHEUMATOLOGY	33,196	0	19,287	0	10,092	90.03
90.04	09004	SPECIALTY CLINIC	8,305	0	4,825	0	12,505	90.04
90.05	09005	PEDIATRICS	67,269	0	39,084	0	10,969	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	8,337	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	89,000	15,816	51,710	0	38,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	86,001	0	49,968	0	3,730	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,600,116	152,510	899,408	414,834	404,544	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	19,609	0	11,393	0	2,194	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,619,725	152,510	910,801	414,834	406,738	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	227,319					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	337,095				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	438	737,055			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,913	7,723	316,684	3,148,894	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,492	95,711	0	1,517,163	0	50.00
51.00	05100	RECOVERY ROOM	1,578	1,357	69,645	183,478	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,094	9,592	84,324	2,153,540	0	54.00
54.01	05401	ONCOLOGY	17,853	6,060	0	994,927	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	29,269	114,121	0	2,352,477	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	861	1,562	174,296	0	65.00
66.00	06600	PHYSICAL THERAPY	10,837	1,015	0	676,720	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,143	325	0	432,539	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,452	218	0	160,440	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,868	491	0	234,722	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,097	0	556,240	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	37,081	0	239,058	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,291	3,498	0	6,607,428	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	3,246	0	2,357,560	0	88.00
90.00	09000	CLINIC	0	12,455	0	1,999,035	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	844	0	207,035	0	90.01
90.02	09002	ORTHOPAEDICS	0	9	0	89,960	0	90.02
90.03	09003	RHEUMATOLOGY	0	469	0	217,808	0	90.03
90.04	09004	SPECIALTY CLINIC	0	4,413	0	296,100	0	90.04
90.05	09005	PEDIATRICS	0	1,183	0	420,578	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	7,929	716	0	202,827	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	15,260	0	90.08
91.00	09100	EMERGENCY	36,771	10,193	264,840	3,698,501	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,580	979	0	393,164	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,319	337,095	737,055	29,329,750	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	156,582	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	227,319	337,095	737,055	29,486,332	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	3,148,894	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1,517,163	50.00
51.00	05100	RECOVERY ROOM	183,478	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,153,540	54.00
54.01	05401	ONCOLOGY	994,927	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000	LABORATORY	2,352,477	60.00
65.00	06500	RESPIRATORY THERAPY	174,296	65.00
66.00	06600	PHYSICAL THERAPY	676,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	432,539	67.00
68.00	06800	SPEECH PATHOLOGY	160,440	68.00
69.00	06900	ELECTROCARDIOLOGY	234,722	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	556,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	239,058	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,607,428	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,357,560	88.00
90.00	09000	CLINIC	1,999,035	90.00
90.01	09001	SURGICAL ASSOCIATES	207,035	90.01
90.02	09002	ORTHOPAEDICS	89,960	90.02
90.03	09003	RHEUMATOLOGY	217,808	90.03
90.04	09004	SPECIALTY CLINIC	296,100	90.04
90.05	09005	PEDIATRICS	420,578	90.05
90.06	09006	WOMEN'S HEALTH	0	90.06
90.07	09007	PAIN MANAGEMENT	202,827	90.07
90.08	09008	ONCOLOGY MD	15,260	90.08
91.00	09100	EMERGENCY	3,698,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	393,164	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,329,750	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	FOUNDATION	156,582	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	193.02
194.00	07950	NON REIMBURSABLE	0	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,486,332	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,478	15,478	15,478		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	294,338	294,338	2,525	296,863	5.00
7.00	00700	OPERATION OF PLANT	0	155,778	155,778	313	16,307	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,315	15,315	0	1,382	8.00
9.00	00900	HOUSEKEEPING	0	37,184	37,184	394	8,691	9.00
10.00	01000	DIETARY	0	64,677	64,677	112	3,110	10.00
11.00	01100	CAFETERIA	0	21,497	21,497	253	3,755	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,293	14,293	112	2,041	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,946	45,946	67	2,622	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,398	30,398	332	6,695	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	152,757	152,757	1,044	20,062	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	126,147	126,147	994	11,753	50.00
51.00	05100	RECOVERY ROOM	0	14,595	14,595	37	868	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	143,856	143,856	1,027	17,838	54.00
54.01	05401	ONCOLOGY	0	51,244	51,244	446	8,777	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	48,642	48,642	613	21,163	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,044	3,044	76	1,601	65.00
66.00	06600	PHYSICAL THERAPY	0	50,710	50,710	303	5,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,056	20,056	218	3,895	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,206	4,206	85	1,495	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,343	9,343	118	2,111	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,034	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,415	39,415	540	65,544	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	94,796	94,796	1,207	21,856	88.00
90.00	09000	CLINIC	0	276,441	276,441	1,754	15,008	90.00
90.01	09001	SURGICAL ASSOCIATES	0	36,487	36,487	52	1,457	90.01
90.02	09002	ORTHOPAEDICS	0	25,053	25,053	32	508	90.02
90.03	09003	RHEUMATOLOGY	0	33,443	33,443	502	1,558	90.03
90.04	09004	SPECIALTY CLINIC	0	8,366	8,366	373	2,679	90.04
90.05	09005	PEDIATRICS	0	67,768	67,768	365	3,041	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	474	1,871	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	154	90.08
91.00	09100	EMERGENCY	0	89,660	89,660	978	32,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	86,639	86,639	72	2,506	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,077,572	2,077,572	15,418	295,621	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	19,754	19,754	60	1,242	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,097,326	2,097,326	15,478	296,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	172,398					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,618	18,315				8.00
9.00	00900	HOUSEKEEPING	3,929	1,285	51,483			9.00
10.00	01000	DIETARY	6,833	527	2,108	77,367		10.00
11.00	01100	CAFETERIA	2,271	0	701	0	28,477	11.00
13.00	01300	NURSING ADMINISTRATION	1,510	0	466	0	154	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,854	0	1,498	0	323	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,212	0	991	0	1,674	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,139	11,942	4,980	77,367	2,795	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,328	1,199	4,112	0	1,659	50.00
51.00	05100	RECOVERY ROOM	1,542	0	476	0	123	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,199	775	4,690	0	1,997	54.00
54.01	05401	ONCOLOGY	5,414	0	1,671	0	1,321	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	5,139	0	1,586	0	2,150	60.00
65.00	06500	RESPIRATORY THERAPY	322	154	99	0	246	65.00
66.00	06600	PHYSICAL THERAPY	5,358	361	1,653	0	799	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,119	166	654	0	445	67.00
68.00	06800	SPEECH PATHOLOGY	444	7	137	0	184	68.00
69.00	06900	ELECTROCARDIOLOGY	987	0	305	0	353	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,164	0	1,285	0	1,121	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	10,016	0	3,090	0	2,427	88.00
90.00	09000	CLINIC	29,207	0	9,012	0	4,346	90.00
90.01	09001	SURGICAL ASSOCIATES	3,855	0	1,189	0	292	90.01
90.02	09002	ORTHOPAEDICS	2,647	0	817	0	15	90.02
90.03	09003	RHEUMATOLOGY	3,533	0	1,090	0	707	90.03
90.04	09004	SPECIALTY CLINIC	884	0	273	0	876	90.04
90.05	09005	PEDIATRICS	7,160	0	2,209	0	768	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	584	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	9,473	1,899	2,923	0	2,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,154	0	2,824	0	261	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,311	18,315	50,839	77,367	28,323	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	2,087	0	644	0	154	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	172,398	18,315	51,483	77,367	28,477	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	18,576					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	55,310				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72	43,374			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,096	1,267	18,637	310,086	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,838	15,704	0	176,734	0	50.00
51.00	05100	RECOVERY ROOM	129	223	4,098	22,091	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,214	1,574	4,962	194,132	0	54.00
54.01	05401	ONCOLOGY	1,459	994	0	71,326	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,392	18,725	0	100,410	0	60.00
65.00	06500	RESPIRATORY THERAPY	266	141	92	6,041	0	65.00
66.00	06600	PHYSICAL THERAPY	886	167	0	65,985	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	502	53	0	28,108	0	67.00
68.00	06800	SPEECH PATHOLOGY	200	36	0	6,794	0	68.00
69.00	06900	ELECTROCARDIOLOGY	398	81	0	13,696	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,954	0	9,312	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,084	0	8,118	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,250	574	0	113,893	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	533	0	133,925	0	88.00
90.00	09000	CLINIC	0	2,044	0	337,812	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	138	0	43,470	0	90.01
90.02	09002	ORTHOPAEDICS	0	1	0	29,073	0	90.02
90.03	09003	RHEUMATOLOGY	0	77	0	40,910	0	90.03
90.04	09004	SPECIALTY CLINIC	0	724	0	14,175	0	90.04
90.05	09005	PEDIATRICS	0	194	0	81,505	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	648	117	0	3,694	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	154	0	90.08
91.00	09100	EMERGENCY	3,005	1,672	15,585	160,031	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	293	161	0	101,910	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,576	55,310	43,374	2,073,385	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	23,941	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,576	55,310	43,374	2,097,326	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	310,086	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	176,734	50.00
51.00	05100	RECOVERY ROOM	22,091	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,132	54.00
54.01	05401	ONCOLOGY	71,326	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000	LABORATORY	100,410	60.00
65.00	06500	RESPIRATORY THERAPY	6,041	65.00
66.00	06600	PHYSICAL THERAPY	65,985	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,108	67.00
68.00	06800	SPEECH PATHOLOGY	6,794	68.00
69.00	06900	ELECTROCARDIOLOGY	13,696	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,893	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC (RHC)	133,925	88.00
90.00	09000	CLINIC	337,812	90.00
90.01	09001	SURGICAL ASSOCIATES	43,470	90.01
90.02	09002	ORTHOPAEDICS	29,073	90.02
90.03	09003	RHEUMATOLOGY	40,910	90.03
90.04	09004	SPECIALTY CLINIC	14,175	90.04
90.05	09005	PEDIATRICS	81,505	90.05
90.06	09006	WOMEN'S HEALTH	0	90.06
90.07	09007	PAIN MANAGEMENT	3,694	90.07
90.08	09008	ONCOLOGY MD	154	90.08
91.00	09100	EMERGENCY	160,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	101,910	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,073,385	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	FOUNDATION	23,941	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	193.02
194.00	07950	NON REIMBURSABLE	0	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,097,326	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	90,246					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	666	16,049,709				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,665	2,614,143	-5,332,962	24,153,370		5.00
7.00	00700	OPERATION OF PLANT	6,703	324,278	0	1,326,778	70,212	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	659	0	0	112,473	659	8.00
9.00	00900	HOUSEKEEPING	1,600	408,323	0	707,069	1,600	9.00
10.00	01000	DIETARY	2,783	115,809	0	253,066	2,783	10.00
11.00	01100	CAFETERIA	925	262,659	0	305,539	925	11.00
13.00	01300	NURSING ADMINISTRATION	615	115,710	0	166,035	615	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,977	69,348	0	213,288	1,977	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,308	344,631	0	544,725	1,308	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,573	1,082,517	0	1,632,243	6,573	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,428	1,031,597	0	956,189	5,428	50.00
51.00	05100	RECOVERY ROOM	628	38,327	0	70,642	628	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,190	1,065,633	0	1,451,346	6,190	54.00
54.01	05401	ONCOLOGY	2,205	462,400	0	714,064	2,205	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,093	635,719	0	1,721,857	2,093	60.00
65.00	06500	RESPIRATORY THERAPY	131	79,077	0	130,285	131	65.00
66.00	06600	PHYSICAL THERAPY	2,182	313,871	0	467,624	2,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	863	226,406	0	316,885	863	67.00
68.00	06800	SPEECH PATHOLOGY	181	88,150	0	121,622	181	68.00
69.00	06900	ELECTROCARDIOLOGY	402	122,190	0	171,736	402	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	435,898	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	165,447	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,696	560,202	0	5,333,220	1,696	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	4,079	1,252,458	0	1,778,250	4,079	88.00
90.00	09000	CLINIC	11,895	1,819,614	0	1,221,050	11,895	90.00
90.01	09001	SURGICAL ASSOCIATES	1,570	54,013	0	118,580	1,570	90.01
90.02	09002	ORTHOPAEDICS	1,078	33,093	0	41,297	1,078	90.02
90.03	09003	RHEUMATOLOGY	1,439	520,745	0	126,773	1,439	90.03
90.04	09004	SPECIALTY CLINIC	360	387,195	0	217,933	360	90.04
90.05	09005	PEDIATRICS	2,916	378,825	0	247,439	2,916	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	491,617	0	152,233	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	12,500	0	90.08
91.00	09100	EMERGENCY	3,858	1,014,426	0	2,614,326	3,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,728	74,332	0	203,888	3,728	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,396	15,987,308	-5,332,962	24,052,300	69,362	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	850	62,401	0	101,070	850	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,097,326	4,863,315		5,332,962	1,619,725	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.240099	0.303016		0.220796	23.069062	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		15,478		296,863	172,398	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000964		0.012291	2.455392	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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,495					8.00
9.00	00900	HOUSEKEEPING	2,000	67,953				9.00
10.00	01000	DIETARY	820	2,783	100			10.00
11.00	01100	CAFETERIA	0	925	0	1,854		11.00
13.00	01300	NURSING ADMINISTRATION	0	615	0	10	226,732	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,977	0	21	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,308	0	109	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,580	6,573	100	182	37,814	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,865	5,428	0	108	22,434	50.00
51.00	05100	RECOVERY ROOM	0	628	0	8	1,574	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205	6,190	0	130	27,024	54.00
54.01	05401	ONCOLOGY	0	2,205	0	86	17,807	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	2,093	0	140	29,193	60.00
65.00	06500	RESPIRATORY THERAPY	240	131	0	16	3,241	65.00
66.00	06600	PHYSICAL THERAPY	561	2,182	0	52	10,809	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	863	0	29	6,127	67.00
68.00	06800	SPEECH PATHOLOGY	11	181	0	12	2,446	68.00
69.00	06900	ELECTROCARDIOLOGY	0	402	0	23	4,855	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,696	0	73	15,252	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	4,079	0	158	0	88.00
90.00	09000	CLINIC	0	11,895	0	283	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	1,570	0	19	0	90.01
90.02	09002	ORTHOPAEDICS	0	1,078	0	1	0	90.02
90.03	09003	RHEUMATOLOGY	0	1,439	0	46	0	90.03
90.04	09004	SPECIALTY CLINIC	0	360	0	57	0	90.04
90.05	09005	PEDIATRICS	0	2,916	0	50	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	38	7,909	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,955	3,858	0	176	36,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,728	0	17	3,571	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,495	67,103	100	1,844	226,732	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	850	0	10	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	152,510	910,801	414,834	406,738	227,319	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.352167	13.403396	4,148.340000	219.384035	1.002589	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,315	51,483	77,367	28,477	18,576	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.642744	0.757627	773.670000	15.359763	0.081929	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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/26/2020 12:31 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			14.00	16.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,504,037		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,956	94,400	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	34,458	40,560	30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	427,037	0	50.00
51.00	05100	RECOVERY ROOM	6,055	8,920	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,796	10,800	54.00
54.01	05401	ONCOLOGY	27,039	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	509,181	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,842	200	65.00
66.00	06600	PHYSICAL THERAPY	4,528	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,448	0	67.00
68.00	06800	SPEECH PATHOLOGY	973	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,191	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	107,517	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	165,447	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,605	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)	14,485	0	88.00
90.00	09000	CLINIC	55,572	0	90.00
90.01	09001	SURGICAL ASSOCIATES	3,766	0	90.01
90.02	09002	ORTHOPAEDICS	39	0	90.02
90.03	09003	RHEUMATOLOGY	2,094	0	90.03
90.04	09004	SPECIALTY CLINIC	19,691	0	90.04
90.05	09005	PEDIATRICS	5,279	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	90.06
90.07	09007	PAIN MANAGEMENT	3,194	0	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	45,478	33,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	4,366	0	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,504,037	94,400	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	337,095	737,055	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.224127	7.807786	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,310	43,374	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.036774	0.459470	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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,148,894		3,148,894	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,517,163		1,517,163	0	0	50.00
51.00	05100	RECOVERY ROOM	183,478		183,478	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,153,540		2,153,540	0	0	54.00
54.01	05401	ONCOLOGY	994,927		994,927	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	2,352,477		2,352,477	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	174,296	0	174,296	0	0	65.00
66.00	06600	PHYSICAL THERAPY	676,720	0	676,720	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	432,539	0	432,539	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	160,440	0	160,440	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	234,722		234,722	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	556,240		556,240	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	239,058		239,058	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,607,428		6,607,428	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,357,560		2,357,560	0	0	88.00
90.00	09000	CLINIC	1,999,035		1,999,035	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	207,035		207,035	0	0	90.01
90.02	09002	ORTHOPAEDICS	89,960		89,960	0	0	90.02
90.03	09003	RHEUMATOLOGY	217,808		217,808	0	0	90.03
90.04	09004	SPECIALTY CLINIC	296,100		296,100	0	0	90.04
90.05	09005	PEDIATRICS	420,578		420,578	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0		0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	202,827		202,827	0	0	90.07
90.08	09008	ONCOLOGY MD	15,260		15,260	0	0	90.08
91.00	09100	EMERGENCY	3,698,501		3,698,501	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	958,360		958,360		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	393,164		393,164	0	0	95.00
200.00		Subtotal (see instructions)	30,288,110	0	30,288,110	0	0	200.00
201.00		Less Observation Beds	958,360		958,360		0	201.00
202.00		Total (see instructions)	29,329,750	0	29,329,750	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,284,179		3,284,179			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,346	4,365,694	4,491,040	0.337820	0.000000	50.00
51.00	05100	RECOVERY ROOM	53,804	1,547,093	1,600,897	0.114609	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597,147	22,753,364	23,350,511	0.092227	0.000000	54.00
54.01	05401	ONCOLOGY	0	792,283	792,283	1.255772	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	760,055	10,392,832	11,152,887	0.210930	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	167,652	267,664	435,316	0.400390	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	265,975	2,328,668	2,594,643	0.260814	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	154,312	1,695,652	1,849,964	0.233809	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	46,096	301,610	347,706	0.461424	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	294,800	3,623,215	3,918,015	0.059908	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	124,564	4,007,975	4,132,539	0.134600	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,566	825,301	844,867	0.282953	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,224	15,282,331	16,154,555	0.409013	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,732	268,286	271,018			88.00
90.00	09000	CLINIC	17,181	513,876	531,057	3.764257	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	26,836	26,836	7.714823	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	22,115	22,115	4.067827	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	107,428	107,428	2.027479	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	239,126	239,126	1.238259	0.000000	90.04
90.05	09005	PEDIATRICS	0	141,141	141,141	2.979843	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	159,264	159,264	1.273527	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	30,494	30,494	0.500426	0.000000	90.08
91.00	09100	EMERGENCY	23,157	6,378,272	6,401,429	0.577762	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,877	920,452	958,329	1.000032	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	562,379	562,379	0.699109	0.000000	95.00
200.00		Subtotal (see instructions)	6,846,667	77,553,351	84,400,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,846,667	77,553,351	84,400,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ONCOLOGY	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC (RHC)		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	90.04
90.05	09005	PEDIATRICS	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	90.07
90.08	09008	ONCOLOGY MD	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/26/2020 12:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,148,894		3,148,894	0	3,148,894	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,517,163		1,517,163	0	1,517,163	50.00
51.00	05100	RECOVERY ROOM	183,478		183,478	0	183,478	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,153,540		2,153,540	0	2,153,540	54.00
54.01	05401	ONCOLOGY	994,927		994,927	0	994,927	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	2,352,477		2,352,477	0	2,352,477	60.00
65.00	06500	RESPIRATORY THERAPY	174,296	0	174,296	0	174,296	65.00
66.00	06600	PHYSICAL THERAPY	676,720	0	676,720	0	676,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	432,539	0	432,539	0	432,539	67.00
68.00	06800	SPEECH PATHOLOGY	160,440	0	160,440	0	160,440	68.00
69.00	06900	ELECTROCARDIOLOGY	234,722		234,722	0	234,722	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	556,240		556,240	0	556,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	239,058		239,058	0	239,058	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,607,428		6,607,428	0	6,607,428	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,357,560		2,357,560	0	2,357,560	88.00
90.00	09000	CLINIC	1,999,035		1,999,035	0	1,999,035	90.00
90.01	09001	SURGICAL ASSOCIATES	207,035		207,035	0	207,035	90.01
90.02	09002	ORTHOPAEDICS	89,960		89,960	0	89,960	90.02
90.03	09003	RHEUMATOLOGY	217,808		217,808	0	217,808	90.03
90.04	09004	SPECIALTY CLINIC	296,100		296,100	0	296,100	90.04
90.05	09005	PEDIATRICS	420,578		420,578	0	420,578	90.05
90.06	09006	WOMEN'S HEALTH	0		0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	202,827		202,827	0	202,827	90.07
90.08	09008	ONCOLOGY MD	15,260		15,260	0	15,260	90.08
91.00	09100	EMERGENCY	3,698,501		3,698,501	0	3,698,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	958,360		958,360		958,360	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	393,164		393,164	0	393,164	95.00
200.00		Subtotal (see instructions)	30,288,110	0	30,288,110	0	30,288,110	200.00
201.00		Less Observation Beds	958,360		958,360		958,360	201.00
202.00		Total (see instructions)	29,329,750	0	29,329,750	0	29,329,750	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 8/26/2020 12:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,284,179		3,284,179			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,346	4,365,694	4,491,040	0.337820	0.000000	50.00
51.00	05100	RECOVERY ROOM	53,804	1,547,093	1,600,897	0.114609	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597,147	22,753,364	23,350,511	0.092227	0.000000	54.00
54.01	05401	ONCOLOGY	0	792,283	792,283	1.255772	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	760,055	10,392,832	11,152,887	0.210930	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	167,652	267,664	435,316	0.400390	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	265,975	2,328,668	2,594,643	0.260814	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	154,312	1,695,652	1,849,964	0.233809	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	46,096	301,610	347,706	0.461424	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	294,800	3,623,215	3,918,015	0.059908	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	124,564	4,007,975	4,132,539	0.134600	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,566	825,301	844,867	0.282953	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,224	15,282,331	16,154,555	0.409013	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,732	268,286	271,018	8.698906	0.000000	88.00
90.00	09000	CLINIC	17,181	513,876	531,057	3.764257	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	26,836	26,836	7.714823	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	22,115	22,115	4.067827	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	107,428	107,428	2.027479	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	239,126	239,126	1.238259	0.000000	90.04
90.05	09005	PEDIATRICS	0	141,141	141,141	2.979843	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	159,264	159,264	1.273527	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	30,494	30,494	0.500426	0.000000	90.08
91.00	09100	EMERGENCY	23,157	6,378,272	6,401,429	0.577762	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,877	920,452	958,329	1.000032	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	562,379	562,379	0.699109	0.000000	95.00
200.00		Subtotal (see instructions)	6,846,667	77,553,351	84,400,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,846,667	77,553,351	84,400,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/26/2020 12:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ONCOLOGY	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	90.04
90.05	09005	PEDIATRICS	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	90.07
90.08	09008	ONCOLOGY MD	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/26/2020 12:31 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	176,734	4,491,040	0.039353	43,453	1,710	50.00
51.00	05100	RECOVERY ROOM	22,091	1,600,897	0.013799	10,621	147	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,132	23,350,511	0.008314	349,620	2,907	54.00
54.01	05401	ONCOLOGY	71,326	792,283	0.090026	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	100,410	11,152,887	0.009003	465,449	4,190	60.00
65.00	06500	RESPIRATORY THERAPY	6,041	435,316	0.013877	108,706	1,509	65.00
66.00	06600	PHYSICAL THERAPY	65,985	2,594,643	0.025431	157,298	4,000	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,108	1,849,964	0.015194	85,018	1,292	67.00
68.00	06800	SPEECH PATHOLOGY	6,794	347,706	0.019539	34,901	682	68.00
69.00	06900	ELECTROCARDIOLOGY	13,696	3,918,015	0.003496	214,029	748	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,312	4,132,539	0.002253	25,570	58	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,118	844,867	0.009609	4,965	48	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,893	16,154,555	0.007050	510,996	3,603	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	133,925	271,018	0.494155	0	0	88.00
90.00	09000	CLINIC	337,812	531,057	0.636113	11,800	7,506	90.00
90.01	09001	SURGICAL ASSOCIATES	43,470	26,836	1.619839	0	0	90.01
90.02	09002	ORTHOPAEDICS	29,073	22,115	1.314628	0	0	90.02
90.03	09003	RHEUMATOLOGY	40,910	107,428	0.380813	0	0	90.03
90.04	09004	SPECIALTY CLINIC	14,175	239,126	0.059278	0	0	90.04
90.05	09005	PEDIATRICS	81,505	141,141	0.577472	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	3,694	159,264	0.023194	0	0	90.07
90.08	09008	ONCOLOGY MD	154	30,494	0.005050	0	0	90.08
91.00	09100	EMERGENCY	160,031	6,401,429	0.024999	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	94,375	958,329	0.098479	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,755,764	80,553,460		2,022,426	28,400	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304

Period: From 01/01/2019 To 12/31/2019

Worksheet D Part IV

Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,491,040	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,600,897	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,350,511	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	792,283	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	11,152,887	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	435,316	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,594,643	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,849,964	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	347,706	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,918,015	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,132,539	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	844,867	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,154,555	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	271,018	0.000000	88.00
90.00	09000	CLINIC	0	0	0	531,057	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	26,836	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	22,115	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	107,428	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	239,126	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	141,141	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	159,264	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	30,494	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	6,401,429	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	958,329	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	80,553,460		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	43,453	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	10,621	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	349,620	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	465,449	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	108,706	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	157,298	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	85,018	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	34,901	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	214,029	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	25,570	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	4,965	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	510,996	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	11,800	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,022,426	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.337820	0	1,964,440	0	0	50.00
51.00	05100	RECOVERY ROOM	0.114609	0	365,658	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092227	0	6,907,793	0	0	54.00
54.01	05401	ONCOLOGY	1.255772	0	504,763	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.210930	0	3,617,306	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.400390	0	84,810	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.260814	0	871,596	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233809	0	656,621	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.461424	0	45,078	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059908	0	1,532,658	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.134600	0	57,181	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.282953	0	204,556	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409013	0	8,392,340	32,855	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.00
90.00	09000	CLINIC	3.764257	0	117,088	11,520	0	90.00
90.01	09001	SURGICAL ASSOCIATES	7.714823	0	15,486	0	0	90.01
90.02	09002	ORTHOPAEDICS	4.067827	0	13,270	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.027479	0	60,798	0	0	90.03
90.04	09004	SPECIALTY CLINIC	1.238259	0	118,581	0	0	90.04
90.05	09005	PEDIATRICS	2.979843	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.273527	0	32,950	0	0	90.07
90.08	09008	ONCOLOGY MD	0.500426	0	26,828	0	0	90.08
91.00	09100	EMERGENCY	0.577762	0	1,396,503	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.000032	0	366,348	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.699109		0			95.00
200.00		Subtotal (see instructions)		0	27,352,652	44,375	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	27,352,652	44,375	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	663,627	0	50.00
51.00	05100	RECOVERY ROOM	41,908	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	637,085	0	54.00
54.01	05401	ONCOLOGY	633,867	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	762,998	0	60.00
65.00	06500	RESPIRATORY THERAPY	33,957	0	65.00
66.00	06600	PHYSICAL THERAPY	227,324	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,524	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,800	0	68.00
69.00	06900	ELECTROCARDIOLOGY	91,818	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,697	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	57,880	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,432,576	13,438	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	88.00
90.00	09000	CLINIC	440,749	43,364	90.00
90.01	09001	SURGICAL ASSOCIATES	119,472	0	90.01
90.02	09002	ORTHOPAEDICS	53,980	0	90.02
90.03	09003	RHEUMATOLOGY	123,267	0	90.03
90.04	09004	SPECIALTY CLINIC	146,834	0	90.04
90.05	09005	PEDIATRICS	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	90.06
90.07	09007	PAIN MANAGEMENT	41,963	0	90.07
90.08	09008	ONCOLOGY MD	13,425	0	90.08
91.00	09100	EMERGENCY	806,846	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	366,360	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	8,877,957	56,802	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	8,877,957	56,802	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.337820	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.114609	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092227	0	0	0	0	54.00
54.01	05401	ONCOLOGY	1.255772	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.210930	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.400390	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.260814	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233809	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.461424	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059908	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.134600	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.282953	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409013	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.00
90.00	09000	CLINIC	3.764257	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	7.714823	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	4.067827	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.027479	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	1.238259	0	0	0	0	90.04
90.05	09005	PEDIATRICS	2.979843	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.273527	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0.500426	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.577762	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.000032	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.699109		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ONCOLOGY	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0	0	90.04
90.05	09005	PEDIATRICS	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,972	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,869	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,282	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	56	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	47	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	871	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)	56	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	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)	3,148,894	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)	6,070	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)	97,498	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,051,396	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)	3,051,396	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,632.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,422,029	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,422,029	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	537,941	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,959,970	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	91,428	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)	91,428	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)	587	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,632.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	958,360	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 12:31 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	310,086	3,148,894	0.098475	958,360	94,375	90.00
91.00	Nursing School cost	0	3,148,894	0.000000	958,360	0	91.00
92.00	Allied health cost	0	3,148,894	0.000000	958,360	0	92.00
93.00	All other Medical Education	0	3,148,894	0.000000	958,360	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/26/2020 12:31 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,972	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,869	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,282	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	56	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	47	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	53	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	3,148,894	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)	91,604	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,057,290	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)	3,057,290	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,635.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	86,697	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)	86,697	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/26/2020 12:31 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	66,541	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	153,238	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	587	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,635.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	960,209	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 12:31 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	310,086	3,148,894	0.098475	960,209	94,557	90.00
91.00	Nursing School cost	0	3,148,894	0.000000	960,209	0	91.00
92.00	Allied health cost	0	3,148,894	0.000000	960,209	0	92.00
93.00	All other Medical Education	0	3,148,894	0.000000	960,209	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/26/2020 12:31 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,441,758		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.337820	43,453	14,679	50.00
51.00	05100	RECOVERY ROOM	0.114609	10,621	1,217	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092227	349,620	32,244	54.00
54.01	05401	ONCOLOGY	1.255772	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.210930	465,449	98,177	60.00
65.00	06500	RESPIRATORY THERAPY	0.400390	108,706	43,525	65.00
66.00	06600	PHYSICAL THERAPY	0.260814	157,298	41,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233809	85,018	19,878	67.00
68.00	06800	SPEECH PATHOLOGY	0.461424	34,901	16,104	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059908	214,029	12,822	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.134600	25,570	3,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.282953	4,965	1,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409013	510,996	209,004	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	09000	CLINIC	3.764257	11,800	44,418	90.00
90.01	09001	SURGICAL ASSOCIATES	7.714823	0	0	90.01
90.02	09002	ORTHOPAEDICS	4.067827	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.027479	0	0	90.03
90.04	09004	SPECIALTY CLINIC	1.238259	0	0	90.04
90.05	09005	PEDIATRICS	2.979843	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.273527	0	0	90.07
90.08	09008	ONCOLOGY MD	0.500426	0	0	90.08
91.00	09100	EMERGENCY	0.577762	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.000032	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,022,426	537,941	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)		2,022,426		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3
Component CCN: 15-Z304 | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.337820	0	0	50.00
51.00	05100	RECOVERY ROOM	0.114609	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092227	4,575	422	54.00
54.01	05401	ONCOLOGY	1.255772	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.210930	7,992	1,686	60.00
65.00	06500	RESPIRATORY THERAPY	0.400390	998	400	65.00
66.00	06600	PHYSICAL THERAPY	0.260814	43,936	11,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233809	27,771	6,493	67.00
68.00	06800	SPEECH PATHOLOGY	0.461424	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059908	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.134600	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.282953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409013	11,936	4,882	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	09000	CLINIC	3.764257	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	7.714823	0	0	90.01
90.02	09002	ORTHOPAEDICS	4.067827	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.027479	0	0	90.03
90.04	09004	SPECIALTY CLINIC	1.238259	0	0	90.04
90.05	09005	PEDIATRICS	2.979843	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.273527	0	0	90.07
90.08	09008	ONCOLOGY MD	0.500426	0	0	90.08
91.00	09100	EMERGENCY	0.577762	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.000032	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		97,208	25,342	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)		97,208		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/26/2020 12:31 pm
	Title XIX	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		162,689		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.337820	6,687	2,259	50.00
51.00	05100	RECOVERY ROOM	0.114609	5,486	629	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092227	75,324	6,947	54.00
54.01	05401	ONCOLOGY	1.255772	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.210930	53,018	11,183	60.00
65.00	06500	RESPIRATORY THERAPY	0.400390	6,552	2,623	65.00
66.00	06600	PHYSICAL THERAPY	0.260814	5,452	1,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233809	3,635	850	67.00
68.00	06800	SPEECH PATHOLOGY	0.461424	682	315	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059908	5,001	300	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.134600	5,442	732	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.282953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409013	56,386	23,063	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	8.698906	539	4,689	88.00
90.00	09000	CLINIC	3.764257	1,259	4,739	90.00
90.01	09001	SURGICAL ASSOCIATES	7.714823	0	0	90.01
90.02	09002	ORTHOPAEDICS	4.067827	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.027479	0	0	90.03
90.04	09004	SPECIALTY CLINIC	1.238259	0	0	90.04
90.05	09005	PEDIATRICS	2.979843	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.273527	0	0	90.07
90.08	09008	ONCOLOGY MD	0.500426	0	0	90.08
91.00	09100	EMERGENCY	0.577762	11,752	6,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.000032	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		237,215	66,541	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)		237,215		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/26/2020 12:31 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,934,759	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8,934,759	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,024,107	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	71,102	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,691,826	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,261,179	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,261,179	30.00
31.00	Primary payer payments	6,093	31.00
32.00	Subtotal (line 30 minus line 31)	4,255,086	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,575,891	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,024,329	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,491,179	36.00
37.00	Subtotal (see instructions)	5,279,415	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,279,415	40.00
40.01	Sequestration adjustment (see instructions)	105,588	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,801,259	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-627,432	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,373,316		5,420,559	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	12/11/2019	140,300	12/11/2019	272,800	3.01
3.02		12/23/2019	55,500	12/23/2019	107,900	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		195,800		380,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,569,116		5,801,259	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		122,808		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		627,432	6.02
7.00	Total Medicare program liability (see instructions)		1,691,924		5,173,827	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I

Component CCN: 15-Z304 | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		85,750		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)		85,750		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		29,828		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		115,578		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: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/26/2020 12:31 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 8/26/2020 12:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	92,342	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	25,595	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	56	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	117,937	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	117,937	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	117,937	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	117,937	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	117,937	0	19.00
19.01	Sequestration adjustment (see instructions)	2,359	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	85,750	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	29,828	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 8/26/2020 12:31 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,959,970	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,959,970	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,979,570	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,979,570	19.00
20.00	Deductibles (exclude professional component)	259,112	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,720,458	22.00
23.00	Coinsurance	682	23.00
24.00	Subtotal (line 22 minus line 23)	1,719,776	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,272	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	6,677	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,342	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,726,453	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,726,453	30.00
30.01	Sequestration adjustment (see instructions)	34,529	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,569,116	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	122,808	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII Date/Time Prepared: 8/26/2020 12:31 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	153,238		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)	153,238	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)	153,238	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	162,689		8.00
9.00	Ancillary service charges	237,215	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)	399,904	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)	399,904	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	246,666	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)	153,238	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)	153,238	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)	153,238	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)	153,238	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	153,238	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)	153,238	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	153,238	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: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 8/26/2020 12:31 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	4,513,554	0	0	0	1.00
2.00	Temporary investments	2,191,486	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,921,737	0	0	0	4.00
5.00	Other receivable	574,333	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,379,709	0	0	0	6.00
7.00	Inventory	1,010,523	0	0	0	7.00
8.00	Prepaid expenses	527,965	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,359,889	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	39,166,665	0	0	0	15.00
16.00	Accumulated depreciation	-23,654,209	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,512,456	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,872,345	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,776,272	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	634,165	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,458,754	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,869,191	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,600,538	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)	3,600,538	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,469,729	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	14,402,616				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)	14,402,616	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,872,345	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 8/26/2020 12:31 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		12,309,961		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,092,655				2.00
3.00	Total (sum of line 1 and line 2)		14,402,616		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)		14,402,616		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,402,616		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/26/2020 12:31 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,284,179		3,284,179	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)	3,284,179		3,284,179	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)	3,284,179		3,284,179	17.00
18.00	Ancillary services	3,481,541	68,183,682	71,665,223	18.00
19.00	Outpatient services	63,215	8,554,004	8,617,219	19.00
20.00	RURAL HEALTH CLINIC (RHC)	2,732	268,286	271,018	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	562,379	562,379	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	396,922	9,170,523	9,567,445	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,228,589	86,738,874	93,967,463	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,186,154		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)		42,186,154		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 8/26/2020 12:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	93,967,463	1.00
2.00	Less contractual allowances and discounts on patients' accounts	51,461,580	2.00
3.00	Net patient revenues (line 1 minus line 2)	42,505,883	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,186,154	4.00
5.00	Net income from service to patients (line 3 minus line 4)	319,729	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 OPERATING EXPENSES/INCOME	496,442	24.00
24.01	NON-OPERATING EXPENSES/INCOME	520,163	24.01
24.02	CONTRACT PHARMACY	756,321	24.02
25.00	Total other income (sum of lines 6-24)	1,772,926	25.00
26.00	Total (line 5 plus line 25)	2,092,655	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)	2,092,655	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 8/26/2020 12:31 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	328,131	0	328,131	394,004	722,135	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	106,765	0	106,765	0	106,765	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	43,865	0	43,865	0	43,865	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	478,761	0	478,761	394,004	872,765	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	7,335	7,335	-1,335	6,000	15.00
16.00	Transportation (Health Care Staff)	0	825	825	0	825	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	155,656	0	155,656	0	155,656	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	155,656	8,160	163,816	-1,335	162,481	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	634,417	8,160	642,577	392,669	1,035,246	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	2,246	2,246	590	2,836	29.00
30.00	Administrative Costs	209,446	41,819	251,265	14,592	265,857	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	209,446	44,065	253,511	15,182	268,693	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	843,863	52,225	896,088	407,851	1,303,939	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1304 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1

Component CCN: 15-8539 | Date/Time Prepared: 8/26/2020 12:31 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	722,135	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	106,765	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	43,865	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	872,765	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	6,000	15.00
16.00	Transportation (Health Care Staff)	0	825	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	155,656	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	162,481	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,035,246	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	2,836	29.00
30.00	Administrative Costs	0	265,857	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	268,693	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,303,939	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 8/26/2020 12:31 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.80	971	4,200	7,560		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.32	1,651	2,100	6,972		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.12	2,622		14,532	14,532	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.12	2,622			14,532	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,035,246	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,035,246	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	268,693	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,053,621	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,322,314	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,322,314	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,322,314	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,357,560	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/26/2020 12:31 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,357,560	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,357,560	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		14,532	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		14,532	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		162.23	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	162.23	162.23	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00