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: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 3/2/2020 11:09 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 3/2/2020 Time: 11:09 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLUFFTON REGIONAL MEDICAL CENTER (15-0075) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

VICE PRESIDENT- REVENUE MANAGEMENT
Title

Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	114,830	37,144	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	78		0	7.00
200.00	Total	0	114,830	37,222	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 3/2/2020 11:09 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 S. MAIN STREET	PO Box:			1.00
2.00	City: BLUFFTON	State: IN	Zip Code: 46714-	County: WELLS	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	BLUFFTON REGIONAL MEDICAL CENTER	150075	23060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLUFFTON SKILLED NURSING	155373	23060		03/13/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	80	69	3	0	465	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 3/2/2020 11:09 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 3/2/2020 11:09 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 3/2/2020 11:09 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 3/2/2020 11:09 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 3/2/2020 11:09 am

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

		1.00	2.00	3.00	
	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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	133,489	57,421	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	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 3/2/2020 11:09 am

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: CHS / COMMUNITY HEALTH SYSTEMS, INC.		Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD		PO Box:		142.00
143.00	City: FRANKLIN		State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	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)	9.99	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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 3/2/2020 11:09 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/31/2020	Y	01/31/2020
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 3/2/2020 11:09 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2018	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 3/2/2020 11:09 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR 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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 3/2/2020 11:09 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	48	17,520	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		48	17,520	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		55	20,075	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	13	4,745		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		68				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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 3/2/2020 11:09 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,115	94	3,220			1.00
2.00	HMO and other (see instructions)	645	436				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,115	94	3,220			7.00
8.00	INTENSIVE CARE UNIT	123	0	306			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		58	389			13.00
14.00	Total (see instructions)	1,238	152	3,915	0.00	203.41	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	1,741	0	3,224	0.00	12.84	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	216.25	27.00
28.00	Observation Bed Days		0	769			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	29	82			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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 3/2/2020 11:09 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	370	194	1,215	1.00
2.00	HMO and other (see instructions)			192	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	370	194	1,215	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part II Date/Time Prepared: 3/2/2020 11:09 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	13,002,206	0	13,002,206	449,805.00	28.91	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	665,456	0	665,456	26,704.00	24.92	9.00
10.00	Excluded area salaries (see instructions)		5,870	0	5,870	194.00	30.26	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		352,174	0	352,174	5,286.00	66.62	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,157,076	0	1,157,076	37,624.00	30.75	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,229,967	0	3,229,967			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,441	0	1,441			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		215,097	0	215,097			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	92,655	0	92,655	2,217.00	41.79	26.00
27.00	Administrative & General	5.00	1,917,368	-176,644	1,740,724	66,507.00	26.17	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part II Date/Time Prepared: 3/2/2020 11:09 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	373,150	0	373,150	13,795.00	27.05	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	296,073	0	296,073	18,800.00	15.75	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	199,948	-115,379	84,569	5,923.00	14.28	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	115,379	115,379	8,081.00	14.28	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,028,753	176,644	1,205,397	29,403.00	41.00	38.00
39.00	Central Services and Supply	14.00	144,497	0	144,497	7,923.00	18.24	39.00
40.00	Pharmacy	15.00	499,027	0	499,027	11,271.00	44.28	40.00
41.00	Medical Records & Medical Records Library	16.00	311,965	0	311,965	14,243.00	21.90	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part III Date/Time Prepared: 3/2/2020 11:09 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		13,002,206	0	13,002,206	449,805.00	28.91	1.00
2.00	Excluded area salaries (see instructions)		671,326	0	671,326	26,898.00	24.96	2.00
3.00	Subtotal salaries (line 1 minus line 2)		12,330,880	0	12,330,880	422,907.00	29.16	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,509,250	0	1,509,250	42,910.00	35.17	4.00
5.00	Subtotal wage-related costs (see inst.)		3,445,064	0	3,445,064	0.00	27.94	5.00
6.00	Total (sum of lines 3 thru 5)		17,285,194	0	17,285,194	465,817.00	37.11	6.00
7.00	Total overhead cost (see instructions)		4,863,436	0	4,863,436	178,163.00	27.30	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part IV Date/Time Prepared: 3/2/2020 11:09 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	324,794	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,661,392	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	14,131	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,802	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	762	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	8,782	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	230,076	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	767,393	17.00
18.00	Medicare Taxes - Employers Portion Only	179,471	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	32,811	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,231,414	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part V Date/Time Prepared: 3/2/2020 11:09 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	352,174	3,231,427	1.00
2.00	Hospital	352,174	3,229,967	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	1,460	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-7 | Date/Time Prepared: 3/2/2020 11:09 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	44	0	44	12.00
13.00		RUB	175	0	175	13.00
14.00		RUA	20	0	20	14.00
15.00		RVC	271	0	271	15.00
16.00		RVB	296	0	296	16.00
17.00		RVA	29	0	29	17.00
18.00		RHC	248	0	248	18.00
19.00		RHB	339	0	339	19.00
20.00		RHA	66	0	66	20.00
21.00		RMC	14	0	14	21.00
22.00		RMB	62	0	62	22.00
23.00		RMA	68	0	68	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	10	0	10	31.00
32.00		HD1	2	0	2	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	27	0	27	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	5	0	5	44.00
45.00		CE2	9	0	9	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	1	0	1	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	12	0	12	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	43	0	43	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-7 | Date/Time Prepared: 3/2/2020 11:09 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,741	0	1,741	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	23060	23060	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,878,146			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-10 | Date/Time Prepared: 3/2/2020 11:09 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.162768	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,771,413	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	30,329,640	6.00
7.00	Medicaid cost (line 1 times line 6)	4,936,695	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)	165,282	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)	165,282	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,929,496	0	2,929,496	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	476,828	0	476,828	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)	476,828	0	476,828	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)	581,565	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	51,061	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	78,556	27.01
28.00	Non-Medicare bad debt expense (see instructions)	503,009	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	109,369	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	586,197	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	751,479	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,152,825	1,152,825	269,287	1,422,112	1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,265,096	4,265,096	382,500	4,647,596	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	92,655	41,627	134,282	2,289,488	2,423,770	4.00
5.01	01160	COMMUNICATIONS	0	0	0	565,650	565,650	5.01
5.02	00540	ADMITTING	0	0	0	523,866	523,866	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	979,619	979,619	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,917,368	11,857,188	13,774,556	-4,890,039	8,884,517	5.04
7.00	00700	OPERATION OF PLANT	373,150	1,652,931	2,026,081	312,736	2,338,817	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	139,115	139,115	0	139,115	8.00
9.00	00900	HOUSEKEEPING	296,073	127,413	423,486	-12,020	411,466	9.00
10.00	01000	DIETARY	199,948	665,408	865,356	-509,087	356,269	10.00
11.00	01100	CAFETERIA	0	0	0	499,349	499,349	11.00
13.00	01300	NURSING ADMINISTRATION	1,028,753	211,287	1,240,040	174,369	1,414,409	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	144,497	607,564	752,061	-342,780	409,281	14.00
15.00	01500	PHARMACY	499,027	1,167,589	1,666,616	-999,012	667,604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	311,965	252,261	564,226	-6,644	557,582	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,899,047	1,323,784	3,222,831	-686,093	2,536,738	30.00
31.00	03100	INTENSIVE CARE UNIT	321,145	84,928	406,073	-2,062	404,011	31.00
43.00	04300	NURSERY	0	0	0	419,225	419,225	43.00
44.00	04400	SKILLED NURSING FACILITY	665,456	137,320	802,776	-10,460	792,316	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,023,811	1,426,716	2,450,527	-307,250	2,143,277	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	264,002	264,002	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	949,612	401,249	1,350,861	-198,952	1,151,909	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	57,146	80,659	137,805	-1,488	136,317	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	895,011	785,573	1,680,584	-67,047	1,613,537	60.00
65.00	06500	RESPIRATORY THERAPY	336,085	48,560	384,645	-2,445	382,200	65.00
66.00	06600	PHYSICAL THERAPY	502,252	70,121	572,373	-3,516	568,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,375	12,427	136,802	0	136,802	67.00
68.00	06800	SPEECH PATHOLOGY	273,534	22,879	296,413	0	296,413	68.00
69.00	06900	ELECTROCARDIOLOGY	40,252	2,928	43,180	0	43,180	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	77,442	77,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	455,352	455,352	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	836,370	836,370	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	111,701	14,230	125,931	0	125,931	76.01
76.03	03953	WOUND CARE	54,126	25,471	79,597	-1,295	78,302	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,983	1,083	5,066	-459	4,607	90.00
91.00	09100	EMERGENCY	875,364	313,269	1,188,633	-8,540	1,180,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,996,336	26,891,501	39,887,837	66	39,887,903	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,247	21,247	-66	21,181	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	5,870	2,056	7,926	0	7,926	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	13,002,206	26,914,804	39,917,010	0	39,917,010	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,298	1,429,410		1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	0		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,475,927	3,171,669		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,082	2,422,688		4.00
5.01	01160	COMMUNICATIONS	-31,592	534,058		5.01
5.02	00540	ADMITTING	0	523,866		5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	979,619		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	58,065	8,942,582		5.04
7.00	00700	OPERATION OF PLANT	0	2,338,817		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	139,115		8.00
9.00	00900	HOUSEKEEPING	0	411,466		9.00
10.00	01000	DIETARY	0	356,269		10.00
11.00	01100	CAFETERIA	-207	499,142		11.00
13.00	01300	NURSING ADMINISTRATION	-35,338	1,379,071		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	409,281		14.00
15.00	01500	PHARMACY	0	667,604		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-380	557,202		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-709,232	1,827,506		30.00
31.00	03100	INTENSIVE CARE UNIT	0	404,011		31.00
43.00	04300	NURSERY	0	419,225		43.00
44.00	04400	SKILLED NURSING FACILITY	0	792,316		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,244,240	899,037		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	264,002		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-27,400	1,124,509		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	136,317		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,613,537		60.00
65.00	06500	RESPIRATORY THERAPY	0	382,200		65.00
66.00	06600	PHYSICAL THERAPY	0	568,857		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	136,802		67.00
68.00	06800	SPEECH PATHOLOGY	0	296,413		68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,180		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	77,442		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	455,352		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	836,370		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	125,931		76.01
76.03	03953	WOUND CARE	0	78,302		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	4,607		90.00
91.00	09100	EMERGENCY	-99,823	1,080,270		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,559,858	36,328,045		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,181		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0		194.00
194.01	07955	MARKETING	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	7,926		194.02
194.03	07953	BUSINESS HEALTH	0	0		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,559,858	36,357,152		200.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 3/2/2020 11:09 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,294,187	1.00
	TOTALS		0	2,294,187	
	B - RECLASS RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	47,608	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	375,733	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
	TOTALS		0	423,341	
	C - RECLASS OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	72,805	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	148,874	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,767	3.00
	TOTALS		0	228,446	
	D - RECLASS REPAIRS & MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	326,037	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	326,037	
	E - RECLASS CNO COSTS				
1.00	NURSING ADMINISTRATION	13.00	176,644	0	1.00
	TOTALS		176,644	0	
	F - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	77,442	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	455,352	2.00
	TOTALS		0	532,794	
	G - RECLASS COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	836,370	1.00
	TOTALS		0	836,370	
	H - RECLASS LABOR AND DELIVERY COSTS				
1.00	NURSERY	43.00	281,266	137,959	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	177,124	86,878	2.00
	TOTALS		458,390	224,837	
	I - RECLASS A PORTION OF DIETARY TO CAFE				
1.00	CAFETERIA	11.00	115,379	383,970	1.00
	TOTALS		115,379	383,970	

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 3/2/2020 11:09 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - RECLASS ADMIN AND GENERAL COSTS					
1.00	COMMUNICATIONS	5.01	70,200	495,450		1.00
2.00	ADMITTING	5.02	461,787	62,079		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	74,241	905,378		3.00
	TOTALS		606,228	1,462,907		
500.00	Grand Total: Increases		1,356,641	6,712,889		500.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 3/2/2020 11:09 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2,294,187	0		1.00
	TOTALS		0	2,294,187			
	B - RECLASS RENTAL AND LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,234	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	13,718	10		2.00
3.00	OPERATION OF PLANT	7.00	0	13,301	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,534	0		4.00
5.00	DIETARY	10.00	0	1,534	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	1,238	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,595	0		7.00
8.00	PHARMACY	15.00	0	146,595	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,106	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	1,711	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	1,267	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	3,214	0		12.00
13.00	OPERATING ROOM	50.00	0	3,635	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	173,420	0		14.00
15.00	LABORATORY	60.00	0	31,630	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,185	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,452	0		17.00
18.00	WOUND CARE	76.03	0	1,269	0		18.00
19.00	CLINIC	90.00	0	459	0		19.00
20.00	EMERGENCY	91.00	0	2,178	0		20.00
21.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	66	0		21.00
	TOTALS		0	423,341			
	C - RECLASS OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	228,446	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	228,446			
	D - RECLASS REPAIRS & MAINTENANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,465	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	107,909	0		2.00
3.00	HOUSEKEEPING	9.00	0	10,486	0		3.00
4.00	DIETARY	10.00	0	8,204	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	1,037	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	37,680	0		6.00
7.00	PHARMACY	15.00	0	16,047	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,538	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,155	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	795	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	7,246	0		11.00
12.00	OPERATING ROOM	50.00	0	61,326	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,532	0		13.00
14.00	RADIOISOTOPE	56.00	0	1,488	0		14.00
15.00	LABORATORY	60.00	0	35,417	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,260	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	1,064	0		17.00
18.00	WOUND CARE	76.03	0	26	0		18.00
19.00	EMERGENCY	91.00	0	6,362	0		19.00
	TOTALS		0	326,037			
	E - RECLASS CNO COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	176,644	0	0		1.00
	TOTALS		176,644	0			
	F - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	290,505	0		1.00
2.00	OPERATING ROOM	50.00	0	242,289	0		2.00
	TOTALS		0	532,794			
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	836,370	0		1.00
	TOTALS		0	836,370			
	H - RECLASS LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	458,390	224,837	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		458,390	224,837			

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 3/2/2020 11:09 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - RECLASS A PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	115,379	383,970	0		1.00
	TOTALS		115,379	383,970			
	J - RECLASS ADMIN AND GENERAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	606,228	1,462,907	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		606,228	1,462,907			
500.00	Grand Total: Decreases		1,356,641	6,712,889			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part I | Date/Time Prepared: 3/2/2020 11:09 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,844,900	0	0	0	0	1.00
2.00	Land Improvements	719,024	0	0	0	0	2.00
3.00	Buildings and Fixtures	20,253,214	0	0	0	0	3.00
4.00	Building Improvements	7,196,542	803,605	0	803,605	0	4.00
5.00	Fixed Equipment	2,491,374	0	0	0	0	5.00
6.00	Movable Equipment	17,847,371	9,575,595	0	9,575,595	62,702	6.00
7.00	HIT designated Assets	5,591,294	66,939	0	66,939	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,943,719	10,446,139	0	10,446,139	62,702	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	57,943,719	10,446,139	0	10,446,139	62,702	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,844,900	0	1.00
2.00	Land Improvements	719,024	0	2.00
3.00	Buildings and Fixtures	20,253,214	0	3.00
4.00	Building Improvements	8,000,147	0	4.00
5.00	Fixed Equipment	2,491,374	0	5.00
6.00	Movable Equipment	27,360,264	0	6.00
7.00	HIT designated Assets	5,658,233	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,327,156	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	68,327,156	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part II | Date/Time Prepared: 3/2/2020 11:09 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,152,825	0	0	0	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	4,265,096	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,417,921	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,152,825	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,265,096	2.00
3.00	Total (sum of lines 1-2)	0	5,417,921	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 3/2/2020 11:09 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	40,966,892	0	40,966,892	0.599570	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	27,360,264	0	27,360,264	0.400430	0	2.00
3.00	Total (sum of lines 1-2)	68,327,156	0	68,327,156	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	824,059	47,608	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,088,324	375,733	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,912,383	423,341	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	72,805	148,874	336,064	1,429,410	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	-1,309,700	0	17,312	3,171,669	2.00
3.00	Total (sum of lines 1-2)	0	-1,236,895	148,874	353,376	4,601,079	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 3/2/2020 11:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - WELLS CRC COSTS-BLDG & FIXT (chapter 2)		0	WELLS CRC COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-31,592	COMMUNICATIONS	5.01	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	-1,458,575			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	-924,748			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-207	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-380	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	22,547	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - WELLS CRC COSTS-BLDG & FIXT		0	WELLS CRC COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-176,772	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 3/2/2020 11:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INSERVICE EDUCATION	B	-35,338	NURSING ADMINISTRATION	13.00	0	33.00
33.01	FITNESS REVENUE	B	-5,640	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02	OTHER MISC REVENUE	B	-17,414	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.04	PATIENT PHONES BENEFITS	A	-1,082	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING	A	5,995	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06	LOBBYING EXPENSE	A	-1,800	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	PHYSICIAN RECRUITING	A	-215	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08	CHARITABLE CONTRIBUTIONS	A	-34,695	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	CRNA COSTS	A	-622,120	OPERATING ROOM	50.00	0	33.09
33.10	PENALTIES/LATE FEES	A	-920	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.11	MEMBERSHIPS/DUES	A	-35,528	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	LEGAL FEES	A	-11,942	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	MARKETING DEPARTMENT	A	-229,432	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,559,858				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 3/2/2020 11:09 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	115,239	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	8,651	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	908	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI OPERATING COSTS	94,593	178,601	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	SHARED SERVICE CENTER ALLOCA	768,376	472,194	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - BUILDING & FIX	16,404	0	4.02
4.03	5.04	OTHER ADMINISTRATIVE AND GEN	NEW CAPITAL - MOVABLE EQUIPM	89,777	0	4.03
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	1,080,839	0	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	MALPRACTICE COSTS	190,910	542,223	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	MANAGEMENT FEES	0	1,316,467	4.06
4.07	5.04	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	5,460	4.07
4.08	5.04	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	26,522	4.08
4.09	5.04	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	547,371	4.09
4.10	5.04	OTHER ADMINISTRATIVE AND GEN	HIIM ALLOCATION	0	192,971	4.10
4.11	5.04	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	2,613	4.11
4.12	5.04	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	6,023	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,365,697	3,290,445	5.00

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

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

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

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

6.00	B	CHS, INC.	100.00	CHS, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 3/2/2020 11:09 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	115,239	14		1.00
2.00	8,651	14		2.00
3.00	908	14		3.00
4.00	-84,008	14		4.00
4.01	296,182	14		4.01
4.02	16,404	14		4.02
4.03	89,777	0		4.03
4.04	1,080,839	0		4.04
4.05	-351,313	9		4.05
4.06	-1,316,467	12		4.06
4.07	-5,460	0		4.07
4.08	-26,522	0		4.08
4.09	-547,371	0		4.09
4.10	-192,971	0		4.10
4.11	-2,613	0		4.11
4.12	-6,023	0		4.12
5.00	-924,748			5.00

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

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

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

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

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 3/2/2020 11:09 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	709,232	709,232	0	0	0	1.00
2.00	50.00	OPERATING ROOM	622,120	622,120	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	27,400	27,400	0	0	0	3.00
4.00	91.00	EMERGENCY	99,823	99,823	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,458,575	1,458,575	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	709,232		1.00
2.00	50.00	OPERATING ROOM	0	0	0	622,120		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	27,400		3.00
4.00	91.00	EMERGENCY	0	0	0	99,823		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,458,575		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,429,410	1,429,410				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	0	0			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,171,669			3,171,669		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,422,688	0	0	21,619	2,444,307	4.00
5.01	01160	COMMUNICATIONS	534,058	7,176	0	13,878	13,292	5.01
5.02	00540	ADMITTING	523,866	9,512	0	18,396	87,435	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	979,619	14,010	0	27,094	14,057	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	8,942,582	143,873	0	278,243	214,807	5.04
7.00	00700	OPERATION OF PLANT	2,338,817	82,850	0	160,227	70,653	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	139,115	1,397	0	41,267	0	8.00
9.00	00900	HOUSEKEEPING	411,466	5,902	0	11,415	56,059	9.00
10.00	01000	DIETARY	356,269	57,982	0	112,133	16,012	10.00
11.00	01100	CAFETERIA	499,142	0	0	49,656	21,846	11.00
13.00	01300	NURSING ADMINISTRATION	1,379,071	2,911	0	5,630	228,231	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	409,281	71,889	0	139,030	27,359	14.00
15.00	01500	PHARMACY	667,604	0	0	0	94,486	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	557,202	17,088	0	33,047	59,068	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,827,506	121,400	0	234,780	272,777	30.00
31.00	03100	INTENSIVE CARE UNIT	404,011	21,389	0	41,366	60,806	31.00
43.00	04300	NURSERY	419,225	3,559	0	6,883	53,255	43.00
44.00	04400	SKILLED NURSING FACILITY	792,316	43,426	0	83,984	125,998	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	899,037	114,253	0	220,959	193,849	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	264,002	4,192	0	8,107	33,537	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,124,509	79,538	0	153,823	179,800	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	136,317	5,182	0	10,021	10,820	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,613,537	32,939	0	63,702	169,462	60.00
65.00	06500	RESPIRATORY THERAPY	382,200	38,637	0	74,723	63,635	65.00
66.00	06600	PHYSICAL THERAPY	568,857	35,857	0	69,346	95,097	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,802	0	0	0	23,549	67.00
68.00	06800	SPEECH PATHOLOGY	296,413	0	0	0	51,791	68.00
69.00	06900	ELECTROCARDIOLOGY	43,180	0	0	18,241	7,621	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	77,442	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	455,352	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	836,370	10,662	0	41,239	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	125,931	2,525	0	4,884	21,150	76.01
76.03	03953	WOUND CARE	78,302	0	0	0	10,248	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,607	7,816	0	15,116	754	90.00
91.00	09100	EMERGENCY	1,080,270	34,627	0	66,968	165,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,328,045	970,592	0	2,025,777	2,443,196	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,181	6,717	0	12,991	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	436,185	0	1,073,365	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	7,926	15,916	0	0	1,111	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	59,536	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,357,152	1,429,410	0	3,171,669	2,444,307	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	COMMUNICATIONS	Subtotal	ADMITTING	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	568,404					5.01
5.02	00540	ADMITTING	9,277	648,486	648,486			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	6,747	1,041,527	18,914	1,060,441	1,060,441	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	43,853	9,623,358	174,779	9,798,137	294,363	5.04
7.00	00700	OPERATION OF PLANT	10,120	2,662,667	48,354	2,711,021	81,450	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	843	182,622	3,316	185,938	5,586	8.00
9.00	00900	HOUSEKEEPING	1,687	486,529	8,835	495,364	14,883	9.00
10.00	01000	DIETARY	7,590	549,986	9,988	559,974	16,824	10.00
11.00	01100	CAFETERIA	0	570,644	10,363	581,007	17,456	11.00
13.00	01300	NURSING ADMINISTRATION	2,530	1,618,373	29,390	1,647,763	49,505	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,217	651,776	11,836	663,612	19,938	14.00
15.00	01500	PHARMACY	9,277	771,367	14,008	785,375	23,596	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,083	687,488	12,485	699,973	21,030	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,867	2,473,330	44,916	2,518,246	75,658	30.00
31.00	03100	INTENSIVE CARE UNIT	4,217	531,789	9,657	541,446	16,267	31.00
43.00	04300	NURSERY	843	483,765	8,785	492,550	14,798	43.00
44.00	04400	SKILLED NURSING FACILITY	8,433	1,054,157	19,143	1,073,300	32,246	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,673	1,456,771	26,455	1,483,226	44,562	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,687	311,525	5,657	317,182	9,529	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,710	1,555,380	28,246	1,583,626	47,578	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	1,687	164,027	2,979	167,006	5,018	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	16,023	1,895,663	34,425	1,930,088	57,988	60.00
65.00	06500	RESPIRATORY THERAPY	2,530	561,725	10,201	571,926	17,183	65.00
66.00	06600	PHYSICAL THERAPY	4,217	773,374	14,044	787,418	23,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	160,351	2,912	163,263	4,905	67.00
68.00	06800	SPEECH PATHOLOGY	0	348,204	6,323	354,527	10,651	68.00
69.00	06900	ELECTROCARDIOLOGY	5,060	74,102	1,346	75,448	2,267	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	77,442	1,406	78,848	2,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	455,352	8,269	463,621	13,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	888,271	16,131	904,402	27,172	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	154,490	2,806	157,296	4,726	76.01
76.03	03953	WOUND CARE	0	88,550	1,608	90,158	2,709	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,217	32,510	590	33,100	994	90.00
91.00	09100	EMERGENCY	14,337	1,361,944	24,733	1,386,677	41,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	243,725	34,397,545	612,900	34,361,959	1,000,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,373	44,262	804	45,066	1,354	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	321,306	1,830,856	33,248	1,864,104	56,005	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	24,953	453	25,406	763	194.02
194.03	07953	BUSINESS HEALTH	0	59,536	1,081	60,617	1,821	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	568,404	36,357,152	648,486	36,357,152	1,060,441	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.03	5.04	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	10,092,500	10,092,500				5.04
7.00	00700	OPERATION OF PLANT	2,792,471	1,073,031	3,865,502			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	191,524	73,595	60,145	325,264		8.00
9.00	00900	HOUSEKEEPING	510,247	196,069	16,636	0	722,952	9.00
10.00	01000	DIETARY	576,798	221,642	163,430	0	31,185	10.00
11.00	01100	CAFETERIA	598,463	229,967	72,371	0	13,810	11.00
13.00	01300	NURSING ADMINISTRATION	1,697,268	652,196	8,205	0	1,566	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	683,550	262,662	202,631	0	38,665	14.00
15.00	01500	PHARMACY	808,971	310,857	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	721,003	277,054	48,165	0	9,191	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,593,904	996,739	342,184	143,112	65,294	30.00
31.00	03100	INTENSIVE CARE UNIT	557,713	214,308	60,289	8,796	11,504	31.00
43.00	04300	NURSERY	507,348	194,955	10,031	0	1,914	43.00
44.00	04400	SKILLED NURSING FACILITY	1,105,546	424,819	122,403	0	23,357	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,527,788	587,071	322,040	62,856	61,451	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	326,711	125,543	11,816	0	2,255	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,631,204	626,810	224,191	36,549	42,779	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	172,024	66,102	14,606	0	2,787	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,988,076	763,942	92,844	0	17,716	60.00
65.00	06500	RESPIRATORY THERAPY	589,109	226,372	108,906	1,207	20,781	65.00
66.00	06600	PHYSICAL THERAPY	811,075	311,665	101,069	2,179	19,286	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,168	64,621	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	365,178	140,324	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	77,715	29,863	26,585	0	5,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,217	31,209	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	477,550	183,504	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	931,574	357,968	60,104	0	11,469	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	162,022	62,259	7,118	0	1,358	76.01
76.03	03953	WOUND CARE	92,867	35,685	0	4,594	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,094	13,101	22,031	0	4,204	90.00
91.00	09100	EMERGENCY	1,428,338	548,856	97,603	65,971	18,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,302,016	9,302,789	2,195,403	325,264	404,269	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,420	17,837	18,934	0	3,613	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,920,109	737,825	1,564,393	0	298,513	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	26,169	10,056	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	62,438	23,993	86,772	0	16,557	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,357,152	10,092,500	3,865,502	325,264	722,952	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	993,055					10.00
11.00	01100	CAFETERIA	0	914,611				11.00
13.00	01300	NURSING ADMINISTRATION	0	80,417	2,439,652			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,668	0	1,209,176		14.00
15.00	01500	PHARMACY	0	30,824	0	2,481	1,153,133	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,957	0	607	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	519,845	144,114	1,019,371	48,575	0	30.00
31.00	03100	INTENSIVE CARE UNIT	50,478	24,341	206,244	7,086	0	31.00
43.00	04300	NURSERY	0	20,815	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	422,732	73,023	249,225	8,952	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	89,004	452,262	217,039	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,137	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,952	0	28,448	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	4,152	0	24,470	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	96,454	0	173,434	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	27,867	0	8,884	0	65.00
66.00	06600	PHYSICAL THERAPY	0	42,768	0	8,816	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,133	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	24,341	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,810	0	54	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,960	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	208,089	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	388,678	1,153,133	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	8,929	0	1,870	0	76.01
76.03	03953	WOUND CARE	0	5,175	32,501	8,908	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	171	0	372	0	90.00
91.00	09100	EMERGENCY	0	74,047	480,049	36,122	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	993,055	914,099	2,439,652	1,199,845	1,153,133	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,331	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	512	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	993,055	914,611	2,439,652	1,209,176	1,153,133	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,094,977					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,839	0	5,951,977	0	5,951,977	30.00
31.00	03100	INTENSIVE CARE UNIT	8,697	0	1,149,456	0	1,149,456	31.00
43.00	04300	NURSERY	3,879	0	738,942	0	738,942	43.00
44.00	04400	SKILLED NURSING FACILITY	21,935	0	2,451,992	0	2,451,992	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	175,105	0	3,494,616	0	3,494,616	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,443	0	481,905	0	481,905	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,913	0	2,867,846	0	2,867,846	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	7,251	0	291,392	0	291,392	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	249,491	0	3,381,957	0	3,381,957	60.00
65.00	06500	RESPIRATORY THERAPY	18,536	0	1,001,662	0	1,001,662	65.00
66.00	06600	PHYSICAL THERAPY	29,449	0	1,326,307	0	1,326,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,604	0	258,526	0	258,526	67.00
68.00	06800	SPEECH PATHOLOGY	5,104	0	534,947	0	534,947	68.00
69.00	06900	ELECTROCARDIOLOGY	19,333	0	162,433	0	162,433	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,420	0	183,806	0	183,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,348	0	900,491	0	900,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,323	0	2,974,249	0	2,974,249	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	3,651	0	247,207	0	247,207	76.01
76.03	03953	WOUND CARE	655	0	180,385	0	180,385	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,585	0	75,558	0	75,558	90.00
91.00	09100	EMERGENCY	108,416	0	2,858,026	0	2,858,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,094,977	0	31,513,680	0	31,513,680	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	96,135	0	96,135	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,520,840	0	4,520,840	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	36,737	0	36,737	194.02
194.03	07953	BUSINESS HEALTH	0	0	189,760	0	189,760	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,094,977	0	36,357,152	0	36,357,152	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS WELLS CRC COSTS-BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	21,619	21,619	4.00
5.01	01160	COMMUNICATIONS	0	7,176	0	13,878	21,054	5.01
5.02	00540	ADMITTING	0	9,512	0	18,396	27,908	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	14,010	0	27,094	41,104	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	143,873	0	278,243	422,116	5.04
7.00	00700	OPERATION OF PLANT	0	82,850	0	160,227	243,077	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,397	0	41,267	42,664	8.00
9.00	00900	HOUSEKEEPING	0	5,902	0	11,415	17,317	9.00
10.00	01000	DIETARY	0	57,982	0	112,133	170,115	10.00
11.00	01100	CAFETERIA	0	0	0	49,656	49,656	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,911	0	5,630	8,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,889	0	139,030	210,919	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,088	0	33,047	50,135	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	121,400	0	234,780	356,180	30.00
31.00	03100	INTENSIVE CARE UNIT	0	21,389	0	41,366	62,755	31.00
43.00	04300	NURSERY	0	3,559	0	6,883	10,442	43.00
44.00	04400	SKILLED NURSING FACILITY	0	43,426	0	83,984	127,410	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	114,253	0	220,959	335,212	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,192	0	8,107	12,299	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,538	0	153,823	233,361	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	5,182	0	10,021	15,203	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	32,939	0	63,702	96,641	60.00
65.00	06500	RESPIRATORY THERAPY	0	38,637	0	74,723	113,360	65.00
66.00	06600	PHYSICAL THERAPY	0	35,857	0	69,346	105,203	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	18,241	18,241	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,662	0	41,239	51,901	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	2,525	0	4,884	7,409	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,816	0	15,116	22,932	90.00
91.00	09100	EMERGENCY	0	34,627	0	66,968	101,595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	970,592	0	2,025,777	2,996,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,717	0	12,991	19,708	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	436,185	0	1,073,365	1,509,550	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	15,916	0	0	15,916	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	59,536	59,536	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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	1,429,410	0	3,171,669	4,601,079	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,619					4.00
5.01	01160	COMMUNICATIONS	118	21,172				5.01
5.02	00540	ADMITTING	773	346	29,027			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	124	251	847	42,326		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,900	1,633	7,822	11,752	445,223	5.04
7.00	00700	OPERATION OF PLANT	625	377	2,165	3,251	47,344	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	31	148	223	3,247	8.00
9.00	00900	HOUSEKEEPING	496	63	396	594	8,649	9.00
10.00	01000	DIETARY	142	283	447	671	9,777	10.00
11.00	01100	CAFETERIA	193	0	464	697	10,145	11.00
13.00	01300	NURSING ADMINISTRATION	2,019	94	1,316	1,976	28,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	242	157	530	796	11,587	14.00
15.00	01500	PHARMACY	836	346	627	942	13,713	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	523	785	559	839	12,222	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,408	628	2,011	3,019	43,969	30.00
31.00	03100	INTENSIVE CARE UNIT	538	157	432	649	9,454	31.00
43.00	04300	NURSERY	471	31	393	591	8,600	43.00
44.00	04400	SKILLED NURSING FACILITY	1,115	314	857	1,287	18,740	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,715	1,068	1,184	1,778	25,898	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	297	63	253	380	5,538	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,591	660	1,265	1,899	27,651	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	96	63	133	200	2,916	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,499	597	1,541	2,314	33,700	60.00
65.00	06500	RESPIRATORY THERAPY	563	94	457	686	9,986	65.00
66.00	06600	PHYSICAL THERAPY	841	157	629	944	13,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	208	0	130	196	2,851	67.00
68.00	06800	SPEECH PATHOLOGY	458	0	283	425	6,190	68.00
69.00	06900	ELECTROCARDIOLOGY	67	188	60	90	1,317	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	63	95	1,377	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	370	556	8,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	722	1,084	15,791	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	187	0	126	189	2,746	76.01
76.03	03953	WOUND CARE	91	0	72	108	1,574	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7	157	26	40	578	90.00
91.00	09100	EMERGENCY	1,466	534	1,107	1,663	24,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,609	9,077	27,435	39,934	410,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	126	36	54	787	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,969	1,488	2,235	32,548	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	10	0	20	30	444	194.02
194.03	07953	BUSINESS HEALTH	0	0	48	73	1,058	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	21,619	21,172	29,027	42,326	445,223	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 3/2/2020 11:09 am

		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	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	296,839					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,619	50,932				8.00
9.00	00900	HOUSEKEEPING	1,278	0	28,793			9.00
10.00	01000	DIETARY	12,550	0	1,242	195,227		10.00
11.00	01100	CAFETERIA	5,558	0	550	0	67,263	11.00
13.00	01300	NURSING ADMINISTRATION	630	0	62	0	5,914	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,560	0	1,540	0	1,594	14.00
15.00	01500	PHARMACY	0	0	0	0	2,267	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,699	0	366	0	2,865	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,277	22,411	2,600	102,197	10,597	30.00
31.00	03100	INTENSIVE CARE UNIT	4,630	1,377	458	9,924	1,790	31.00
43.00	04300	NURSERY	770	0	76	0	1,531	43.00
44.00	04400	SKILLED NURSING FACILITY	9,400	0	930	83,106	5,370	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,730	9,842	2,447	0	6,546	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	907	0	90	0	966	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,216	5,723	1,704	0	6,027	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	1,122	0	111	0	305	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,130	0	706	0	7,094	60.00
65.00	06500	RESPIRATORY THERAPY	8,363	189	828	0	2,049	65.00
66.00	06600	PHYSICAL THERAPY	7,761	341	768	0	3,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	598	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,790	68.00
69.00	06900	ELECTROCARDIOLOGY	2,042	0	202	0	280	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,616	0	457	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	547	0	54	0	657	76.01
76.03	03953	WOUND CARE	0	719	0	0	381	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,692	0	167	0	13	90.00
91.00	09100	EMERGENCY	7,495	10,330	742	0	5,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,592	50,932	16,100	195,227	67,225	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,454	0	144	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	120,130	0	11,890	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	38	194.02
194.03	07953	BUSINESS HEALTH	6,663	0	659	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	296,839	50,932	28,793	195,227	67,263	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	49,322					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	242,925				14.00
15.00	01500	PHARMACY	0	498	19,229			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	122	0	72,115		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,609	9,759	0	5,185	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,170	1,424	0	572	0	31.00
43.00	04300	NURSERY	0	0	0	255	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,038	1,799	0	1,443	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,143	43,603	0	11,517	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	161	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,715	0	12,885	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	4,916	0	477	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	34,843	0	16,505	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,785	0	1,219	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,771	0	1,937	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,158	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	336	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11	0	1,272	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,416	0	2,922	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	41,805	0	2,062	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	78,085	19,229	4,691	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	376	0	240	0	76.01
76.03	03953	WOUND CARE	657	1,790	0	43	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	75	0	104	0	90.00
91.00	09100	EMERGENCY	9,705	7,257	0	7,131	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,322	241,050	19,229	72,115	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,875	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	49,322	242,925	19,229	72,115	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00540	ADMITTING					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	607,850	0	607,850		30.00
31.00	03100	INTENSIVE CARE UNIT	98,330	0	98,330		31.00
43.00	04300	NURSERY	23,160	0	23,160		43.00
44.00	04400	SKILLED NURSING FACILITY	256,809	0	256,809		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	474,683	0	474,683		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,954	0	20,954		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	315,697	0	315,697		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	25,542	0	25,542		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	202,570	0	202,570		60.00
65.00	06500	RESPIRATORY THERAPY	139,579	0	139,579		65.00
66.00	06600	PHYSICAL THERAPY	137,246	0	137,246		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,141	0	5,141		67.00
68.00	06800	SPEECH PATHOLOGY	9,482	0	9,482		68.00
69.00	06900	ELECTROCARDIOLOGY	23,770	0	23,770		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,873	0	9,873		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,888	0	52,888		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,576	0	176,576		73.00
76.00	03950	OTHER ANCILLARY	0	0	0		76.00
76.01	03951	SLEEP LAB	12,531	0	12,531		76.01
76.03	03953	WOUND CARE	5,435	0	5,435		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	25,791	0	25,791		90.00
91.00	09100	EMERGENCY	178,683	0	178,683		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,802,590	0	2,802,590		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,184	0	24,184		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,689,810	0	1,689,810		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0		194.00
194.01	07955	MARKETING	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	16,458	0	16,458		194.02
194.03	07953	BUSINESS HEALTH	68,037	0	68,037		194.03
194.04	07954	VACANT SPACE	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	4,601,079	0	4,601,079		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	196,409					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	119,997				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			225,345			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,536	1,536	12,909,551		4.00
5.01	01160	COMMUNICATIONS	986	0	986	70,200	674	5.01
5.02	00540	ADMITTING	1,307	0	1,307	461,787	11	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,925	0	1,925	74,241	8	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	19,769	768	19,769	1,134,496	52	5.04
7.00	00700	OPERATION OF PLANT	11,384	88,106	11,384	373,150	12	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192	2,740	2,932	0	1	8.00
9.00	00900	HOUSEKEEPING	811	0	811	296,073	2	9.00
10.00	01000	DIETARY	7,967	0	7,967	84,569	9	10.00
11.00	01100	CAFETERIA	0	3,528	3,528	115,379	0	11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	1,205,397	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	144,497	5	14.00
15.00	01500	PHARMACY	0	0	0	499,027	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	311,965	25	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,681	0	16,681	1,440,657	20	30.00
31.00	03100	INTENSIVE CARE UNIT	2,939	0	2,939	321,145	5	31.00
43.00	04300	NURSERY	489	0	489	281,266	1	43.00
44.00	04400	SKILLED NURSING FACILITY	5,967	0	5,967	665,456	10	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,699	0	15,699	1,023,811	34	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	177,124	2	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	0	10,929	949,612	21	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	712	0	712	57,146	2	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,526	0	4,526	895,011	19	60.00
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	336,085	3	65.00
66.00	06600	PHYSICAL THERAPY	4,927	0	4,927	502,252	5	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	124,375	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	273,534	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,296	1,296	40,252	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,465	1,465	2,930	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	347	0	347	111,701	0	76.01
76.03	03953	WOUND CARE	0	0	0	54,126	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,074	0	1,074	3,983	5	90.00
91.00	09100	EMERGENCY	4,758	0	4,758	875,364	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,365	99,439	143,930	12,903,681	289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	0	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,934	16,328	76,262	0	381	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	2,187	0	0	5,870	0	194.02
194.03	07953	BUSINESS HEALTH	0	4,230	4,230	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,429,410	0	3,171,669	2,444,307	568,404	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.277721	0.000000	14.074725	0.189341	843.329377	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				21,619	21,172	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT PHONES)	
		1.00	1.01	2.00	4.00	5.01	
205.00	Unit cost multiplier (Wkst. B, Part II)				0.001675	31.412463	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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	
			5A.02	5.02	5A.03	5.03	5A.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING	-648,486	35,708,666				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	1,041,527	-1,060,441	35,296,711		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	9,623,358	0	9,798,137	-10,092,500	5.04
7.00	00700	OPERATION OF PLANT	0	2,662,667	0	2,711,021	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	182,622	0	185,938	0	8.00
9.00	00900	HOUSEKEEPING	0	486,529	0	495,364	0	9.00
10.00	01000	DIETARY	0	549,986	0	559,974	0	10.00
11.00	01100	CAFETERIA	0	570,644	0	581,007	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,618,373	0	1,647,763	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	651,776	0	663,612	0	14.00
15.00	01500	PHARMACY	0	771,367	0	785,375	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	687,488	0	699,973	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,473,330	0	2,518,246	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	531,789	0	541,446	0	31.00
43.00	04300	NURSERY	0	483,765	0	492,550	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,054,157	0	1,073,300	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,456,771	0	1,483,226	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	311,525	0	317,182	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,555,380	0	1,583,626	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	164,027	0	167,006	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,895,663	0	1,930,088	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	561,725	0	571,926	0	65.00
66.00	06600	PHYSICAL THERAPY	0	773,374	0	787,418	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	160,351	0	163,263	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	348,204	0	354,527	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	74,102	0	75,448	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	77,442	0	78,848	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	455,352	0	463,621	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	888,271	0	904,402	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	154,490	0	157,296	0	76.01
76.03	03953	WOUND CARE	0	88,550	0	90,158	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	32,510	0	33,100	0	90.00
91.00	09100	EMERGENCY	0	1,361,944	0	1,386,677	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-648,486	33,749,059	-1,060,441	33,301,518	-10,092,500	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,262	0	45,066	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,830,856	0	1,864,104	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	24,953	0	25,406	0	194.02
194.03	07953	BUSINESS HEALTH	0	59,536	0	60,617	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)		648,486		1,060,441		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.018160		0.030044		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		29,027		42,326		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000813		0.001199		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	
			5A.02	5.02	5A.03	5.03	5A.04	
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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.04	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	26,264,652					5.04
7.00	00700	OPERATION OF PLANT	2,792,471	188,438				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	191,524	2,932	200,279			8.00
9.00	00900	HOUSEKEEPING	510,247	811	0	184,695		9.00
10.00	01000	DIETARY	576,798	7,967	0	7,967	28,939	10.00
11.00	01100	CAFETERIA	598,463	3,528	0	3,528	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,697,268	400	0	400	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	683,550	9,878	0	9,878	0	14.00
15.00	01500	PHARMACY	808,971	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	721,003	2,348	0	2,348	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,593,904	16,681	88,120	16,681	15,149	30.00
31.00	03100	INTENSIVE CARE UNIT	557,713	2,939	5,416	2,939	1,471	31.00
43.00	04300	NURSERY	507,348	489	0	489	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,105,546	5,967	0	5,967	12,319	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,527,788	15,699	38,703	15,699	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	326,711	576	0	576	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,631,204	10,929	22,505	10,929	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	172,024	712	0	712	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,988,076	4,526	0	4,526	0	60.00
65.00	06500	RESPIRATORY THERAPY	589,109	5,309	743	5,309	0	65.00
66.00	06600	PHYSICAL THERAPY	811,075	4,927	1,342	4,927	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,168	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	365,178	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	77,715	1,296	0	1,296	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,217	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	477,550	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	931,574	2,930	0	2,930	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	162,022	347	0	347	0	76.01
76.03	03953	WOUND CARE	92,867	0	2,829	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,094	1,074	0	1,074	0	90.00
91.00	09100	EMERGENCY	1,428,338	4,758	40,621	4,758	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,209,516	107,023	200,279	103,280	28,939	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,420	923	0	923	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,920,109	76,262	0	76,262	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	26,169	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	62,438	4,230	0	4,230	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	10,092,500	3,865,502	325,264	722,952	993,055	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.384262	20.513389	1.624054	3.914302	34.315457	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	445,223	296,839	50,932	28,793	195,227	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.016951	1.575261	0.254305	0.155895	6.746156	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.04	7.00	8.00	9.00	10.00	
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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES IN NURSING ARE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED R EQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	16,082					11.00
13.00	01300	NURSING ADMINISTRATION	1,414	3,589,633				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	381	0	2,744,871			14.00
15.00	01500	PHARMACY	542	0	5,632	887,941		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	685	0	1,379	0	193,610,932	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,534	1,499,873	110,267	0	13,938,995	30.00
31.00	03100	INTENSIVE CARE UNIT	428	303,461	16,085	0	1,537,660	31.00
43.00	04300	NURSERY	366	0	0	0	685,856	43.00
44.00	04400	SKILLED NURSING FACILITY	1,284	366,703	20,322	0	3,878,146	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,565	665,445	492,687	0	30,959,113	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	231	0	0	0	431,912	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,441	0	64,577	0	34,638,150	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	73	0	55,548	0	1,282,003	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,696	0	393,700	0	44,125,933	60.00
65.00	06500	RESPIRATORY THERAPY	490	0	20,168	0	3,277,218	65.00
66.00	06600	PHYSICAL THERAPY	752	0	20,012	0	5,206,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	143	0	0	0	3,112,476	67.00
68.00	06800	SPEECH PATHOLOGY	428	0	0	0	902,486	68.00
69.00	06900	ELECTROCARDIOLOGY	67	0	123	0	3,418,190	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	61,200	0	7,853,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	472,370	0	5,542,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	882,309	887,941	12,610,169	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	157	0	4,246	0	645,543	76.01
76.03	03953	WOUND CARE	91	47,821	20,222	0	115,767	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3	0	845	0	280,321	90.00
91.00	09100	EMERGENCY	1,302	706,330	81,998	0	19,168,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,073	3,589,633	2,723,690	887,941	193,610,932	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,181	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	9	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	914,611	2,439,652	1,209,176	1,153,133	1,094,977	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.871720	0.679638	0.440522	1.298659	0.005656	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	67,263	49,322	242,925	19,229	72,115	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.182502	0.013740	0.088501	0.021656	0.000372	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES IN NURSING ARE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED R EQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160	COMMUNICATIONS			5.01
5.02	00540	ADMITTING			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL			5.04
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
54.01	03630	ULTRA SOUND	0		54.01
56.00	05600	RADIOISOTOPE	0		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	0		58.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03950	OTHER ANCILLARY	0		76.00
76.01	03951	SLEEP LAB	0		76.01
76.03	03953	WOUND CARE	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0		194.00
194.01	07955	MARKETING	0		194.01
194.02	07952	SENIOR CIRCLE	0		194.02
194.03	07953	BUSINESS HEALTH	0		194.03
194.04	07954	VACANT SPACE	0		194.04
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)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet B-1 Date/Time Prepared: 3/2/2020 11:09 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,951,977		5,951,977	0	5,951,977	30.00
31.00	03100	INTENSIVE CARE UNIT	1,149,456		1,149,456	0	1,149,456	31.00
43.00	04300	NURSERY	738,942		738,942	0	738,942	43.00
44.00	04400	SKILLED NURSING FACILITY	2,451,992		2,451,992	0	2,451,992	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,494,616		3,494,616	0	3,494,616	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	481,905		481,905	0	481,905	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,867,846		2,867,846	0	2,867,846	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	291,392		291,392	0	291,392	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,381,957		3,381,957	0	3,381,957	60.00
65.00	06500	RESPIRATORY THERAPY	1,001,662	0	1,001,662	0	1,001,662	65.00
66.00	06600	PHYSICAL THERAPY	1,326,307	0	1,326,307	0	1,326,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,526	0	258,526	0	258,526	67.00
68.00	06800	SPEECH PATHOLOGY	534,947	0	534,947	0	534,947	68.00
69.00	06900	ELECTROCARDIOLOGY	162,433		162,433	0	162,433	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	183,806		183,806	0	183,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	900,491		900,491	0	900,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,974,249		2,974,249	0	2,974,249	73.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	247,207		247,207	0	247,207	76.01
76.03	03953	WOUND CARE	180,385		180,385	0	180,385	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	75,558		75,558	0	75,558	90.00
91.00	09100	EMERGENCY	2,858,026		2,858,026	0	2,858,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,147,425		1,147,425		1,147,425	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	32,661,105	0	32,661,105	0	32,661,105	200.00
201.00		Less Observation Beds	1,147,425		1,147,425		1,147,425	201.00
202.00		Total (see instructions)	31,513,680	0	31,513,680	0	31,513,680	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,897,764		11,897,764			30.00
31.00	03100	INTENSIVE CARE UNIT	1,537,660		1,537,660			31.00
43.00	04300	NURSERY	685,856		685,856			43.00
44.00	04400	SKILLED NURSING FACILITY	3,878,146		3,878,146			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,918,742	24,040,371	30,959,113	0.112878	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	415,696	16,216	431,912	1.115748	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,078,320	30,559,830	34,638,150	0.082794	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	83,590	1,198,413	1,282,003	0.227294	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	7,548,500	36,577,433	44,125,933	0.076643	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,908,435	368,783	3,277,218	0.305644	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,682,021	2,524,606	5,206,627	0.254734	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,564,765	1,547,711	3,112,476	0.083061	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	88,712	813,774	902,486	0.592748	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,392,981	2,025,209	3,418,190	0.047520	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,259,969	4,593,639	7,853,608	0.023404	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,074,658	2,467,736	5,542,394	0.162473	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,193,690	8,416,479	12,610,169	0.235861	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	645,543	645,543	0.382944	0.000000	76.01
76.03	03953	WOUND CARE	4,040	111,727	115,767	1.558173	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,286	251,035	280,321	0.269541	0.000000	90.00
91.00	09100	EMERGENCY	3,207,396	15,960,969	19,168,365	0.149101	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	318,250	1,722,981	2,041,231	0.562124	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	59,768,477	133,842,455	193,610,932			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	59,768,477	133,842,455	193,610,932			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.112878	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.115748	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082794	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.227294	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.076643	60.00
65.00	06500	RESPIRATORY THERAPY	0.305644	65.00
66.00	06600	PHYSICAL THERAPY	0.254734	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.083061	67.00
68.00	06800	SPEECH PATHOLOGY	0.592748	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047520	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.162473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235861	73.00
76.00	03950	OTHER ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.382944	76.01
76.03	03953	WOUND CARE	1.558173	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.269541	90.00
91.00	09100	EMERGENCY	0.149101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.562124	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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 3/2/2020 11:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,951,977		5,951,977	0	5,951,977	30.00
31.00	03100	INTENSIVE CARE UNIT	1,149,456		1,149,456	0	1,149,456	31.00
43.00	04300	NURSERY	738,942		738,942	0	738,942	43.00
44.00	04400	SKILLED NURSING FACILITY	2,451,992		2,451,992	0	2,451,992	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,494,616		3,494,616	0	3,494,616	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	481,905		481,905	0	481,905	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,867,846		2,867,846	0	2,867,846	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	291,392		291,392	0	291,392	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,381,957		3,381,957	0	3,381,957	60.00
65.00	06500	RESPIRATORY THERAPY	1,001,662	0	1,001,662	0	1,001,662	65.00
66.00	06600	PHYSICAL THERAPY	1,326,307	0	1,326,307	0	1,326,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,526	0	258,526	0	258,526	67.00
68.00	06800	SPEECH PATHOLOGY	534,947	0	534,947	0	534,947	68.00
69.00	06900	ELECTROCARDIOLOGY	162,433		162,433	0	162,433	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	183,806		183,806	0	183,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	900,491		900,491	0	900,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,974,249		2,974,249	0	2,974,249	73.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	247,207		247,207	0	247,207	76.01
76.03	03953	WOUND CARE	180,385		180,385	0	180,385	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	75,558		75,558	0	75,558	90.00
91.00	09100	EMERGENCY	2,858,026		2,858,026	0	2,858,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,147,425		1,147,425		1,147,425	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	32,661,105	0	32,661,105	0	32,661,105	200.00
201.00		Less Observation Beds	1,147,425		1,147,425		1,147,425	201.00
202.00		Total (see instructions)	31,513,680	0	31,513,680	0	31,513,680	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 3/2/2020 11:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,897,764		11,897,764			30.00
31.00	03100	INTENSIVE CARE UNIT	1,537,660		1,537,660			31.00
43.00	04300	NURSERY	685,856		685,856			43.00
44.00	04400	SKILLED NURSING FACILITY	3,878,146		3,878,146			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,918,742	24,040,371	30,959,113	0.112878	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	415,696	16,216	431,912	1.115748	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,078,320	30,559,830	34,638,150	0.082794	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	83,590	1,198,413	1,282,003	0.227294	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	7,548,500	36,577,433	44,125,933	0.076643	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,908,435	368,783	3,277,218	0.305644	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,682,021	2,524,606	5,206,627	0.254734	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,564,765	1,547,711	3,112,476	0.083061	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	88,712	813,774	902,486	0.592748	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,392,981	2,025,209	3,418,190	0.047520	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,259,969	4,593,639	7,853,608	0.023404	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,074,658	2,467,736	5,542,394	0.162473	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,193,690	8,416,479	12,610,169	0.235861	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	645,543	645,543	0.382944	0.000000	76.01
76.03	03953	WOUND CARE	4,040	111,727	115,767	1.558173	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,286	251,035	280,321	0.269541	0.000000	90.00
91.00	09100	EMERGENCY	3,207,396	15,960,969	19,168,365	0.149101	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	318,250	1,722,981	2,041,231	0.562124	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	59,768,477	133,842,455	193,610,932			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	59,768,477	133,842,455	193,610,932			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 3/2/2020 11:09 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.03	03953	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		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 ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part I Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	607,850	0	607,850	3,989	152.38	30.00
31.00	INTENSIVE CARE UNIT	98,330		98,330	306	321.34	31.00
43.00	NURSERY	23,160		23,160	389	59.54	43.00
44.00	SKILLED NURSING FACILITY	256,809		256,809	3,224	79.66	44.00
200.00	Total (lines 30 through 199)	986,149		986,149	7,908		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,115	169,904				30.00
31.00	INTENSIVE CARE UNIT	123	39,525				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	1,741	138,688				44.00
200.00	Total (lines 30 through 199)	2,979	348,117				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part II Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	474,683	30,959,113	0.015333	1,478,113	22,664	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,954	431,912	0.048515	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	315,697	34,638,150	0.009114	1,458,163	13,290	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	25,542	1,282,003	0.019924	40,887	815	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	202,570	44,125,933	0.004591	2,409,955	11,064	60.00
65.00	06500	RESPIRATORY THERAPY	139,579	3,277,218	0.042591	886,789	37,769	65.00
66.00	06600	PHYSICAL THERAPY	137,246	5,206,627	0.026360	284,391	7,497	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,141	3,112,476	0.001652	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,482	902,486	0.010507	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,770	3,418,190	0.006954	654,547	4,552	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,873	7,853,608	0.001257	737,596	927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,888	5,542,394	0.009542	1,004,357	9,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,576	12,610,169	0.014003	1,239,648	17,359	73.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	12,531	645,543	0.019412	0	0	76.01
76.03	03953	WOUND CARE	5,435	115,767	0.046948	2,536	119	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,791	280,321	0.092005	3,477	320	90.00
91.00	09100	EMERGENCY	178,683	19,168,365	0.009322	1,319,470	12,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	117,182	2,041,231	0.057408	83,375	4,786	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,933,623	175,611,506		11,603,304	143,046	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part III Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,989	0.00	1,115	30.00
31.00	03100	INTENSIVE CARE UNIT		0	306	0.00	123	31.00
43.00	04300	NURSERY		0	389	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	3,224	0.00	1,741	44.00
200.00		Total (lines 30 through 199)		0	7,908		2,979	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,959,113	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	431,912	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,638,150	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,282,003	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	44,125,933	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,277,218	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,206,627	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,112,476	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	902,486	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,418,190	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,853,608	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,542,394	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,610,169	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	645,543	0.000000	76.01
76.03	03953	WOUND CARE	0	0	0	115,767	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	280,321	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	19,168,365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,041,231	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	175,611,506		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,478,113	0	4,843,378	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,458,163	0	7,075,194	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	40,887	0	391,114	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	2,409,955	0	2,937,030	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	886,789	0	122,393	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	284,391	0	23,212	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	654,547	0	620,636	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	737,596	0	578,999	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,004,357	0	629,323	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,239,648	0	2,894,665	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	99,358	0	76.01
76.03	03953	WOUND CARE	0.000000	2,536	0	24,541	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	3,477	0	78,214	0	90.00
91.00	09100	EMERGENCY	0.000000	1,319,470	0	3,000,615	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	83,375	0	477,625	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		11,603,304	0	23,796,297	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.112878	4,843,378	0	0	546,711	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.115748	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082794	7,075,194	0	0	585,784	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.227294	391,114	0	0	88,898	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.076643	2,937,030	0	0	225,103	60.00
65.00	06500	RESPIRATORY THERAPY	0.305644	122,393	0	0	37,409	65.00
66.00	06600	PHYSICAL THERAPY	0.254734	23,212	0	0	5,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.083061	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.592748	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047520	620,636	0	0	29,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023404	578,999	0	0	13,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.162473	629,323	0	0	102,248	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235861	2,894,665	0	19,075	682,739	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.382944	99,358	0	0	38,049	76.01
76.03	03953	WOUND CARE	1.558173	24,541	0	0	38,239	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.269541	78,214	0	390	21,082	90.00
91.00	09100	EMERGENCY	0.149101	3,000,615	0	0	447,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.562124	477,625	0	0	268,484	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		23,796,297	0	19,465	3,131,098	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		23,796,297	0	19,465	3,131,098	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,499		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.03	03953	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	105		90.00
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	4,604		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	4,604		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		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: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,959,113	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	431,912	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,638,150	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,282,003	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	44,125,933	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,277,218	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,206,627	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,112,476	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	902,486	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,418,190	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,853,608	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,542,394	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,610,169	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	645,543	0.000000	76.01
76.03	03953	WOUND CARE	0	0	0	115,767	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	280,321	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	19,168,365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,041,231	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	175,611,506		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	25,824	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	273,961	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	535,041	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,985,298	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,292	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	326,513	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	506,177	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03953	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
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)		3,656,106	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.112878	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.115748	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082794	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.227294	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.076643	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.305644	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254734	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.083061	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.592748	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047520	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023404	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.162473	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235861	0	0	2,190	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.382944	0	0	0	0	76.01
76.03	03953	WOUND CARE	1.558173	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.269541	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.149101	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.562124	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	2,190	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	2,190	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	517		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.03	03953	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	517		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	517		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 3/2/2020 11:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.112878	0	63,840	989,190	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.115748	0	3,400	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082794	0	209,399	626,863	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.227294	0	0	4,797	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.076643	0	399,268	616,642	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.305644	0	8,292	11,106	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254734	0	255,055	595,548	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.083061	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.592748	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047520	0	14,176	33,620	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023404	0	12,289	160,937	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.162473	0	132	25,511	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235861	0	107,756	122,132	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.382944	0	0	0	0	76.01
76.03	03953	WOUND CARE	1.558173	0	1,748	11,112	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.269541	0	2,350	3,029	0	90.00
91.00	09100	EMERGENCY	0.149101	0	200,488	542,475	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.562124	0	2,952	54,500	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	1,281,145	3,797,462	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	1,281,145	3,797,462	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 3/2/2020 11:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	7,206	111,658		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,794	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,337	51,900		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	1,090		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	30,601	47,261		60.00
65.00	06500	RESPIRATORY THERAPY	2,534	3,394		65.00
66.00	06600	PHYSICAL THERAPY	64,971	151,706		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	674	1,598		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	288	3,767		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21	4,145		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,415	28,806		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.03	03953	WOUND CARE	2,724	17,314		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	633	816		90.00
91.00	09100	EMERGENCY	29,893	80,884		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,659	30,636		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	187,750	534,975		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	187,750	534,975		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,989	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,989	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.	1,092	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,128	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,115	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,951,977	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,951,977	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	3,867,930	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,867,930	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.538802	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)	1,817.64	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,951,977	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)	1,492.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,663,692	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)	1,663,692	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,149,456	306	3,756.39	123	462,036	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,577,481	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,703,209	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)	209,429	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	143,046	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	352,475	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,350,734	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)	769	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,492.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,147,425	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	607,850	5,951,977	0.102126	1,147,425	117,182	90.00
91.00	Nursing School cost	0	5,951,977	0.000000	1,147,425	0	91.00
92.00	Allied health cost	0	5,951,977	0.000000	1,147,425	0	92.00
93.00	All other Medical Education	0	5,951,977	0.000000	1,147,425	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,224	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,224	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.	2,159	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,065	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,741	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,451,992	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,451,992	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,085,711	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,085,711	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.175614	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)	1,958.41	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)	2,451,992	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,451,992	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	760.54	71.00
72.00	Program routine service cost (line 9 x line 71)	1,324,100	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,324,100	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,324,100	83.00
84.00	Program inpatient ancillary services (see instructions)	819,575	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,143,675	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,160,033		30.00
31.00	03100	INTENSIVE CARE UNIT		613,672		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112878	1,478,113	166,846	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.115748	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082794	1,458,163	120,727	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.227294	40,887	9,293	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.076643	2,409,955	184,706	60.00
65.00	06500	RESPIRATORY THERAPY	0.305644	886,789	271,042	65.00
66.00	06600	PHYSICAL THERAPY	0.254734	284,391	72,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.083061	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.592748	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047520	654,547	31,104	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023404	737,596	17,263	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.162473	1,004,357	163,181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235861	1,239,648	292,385	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.382944	0	0	76.01
76.03	03953	WOUND CARE	1.558173	2,536	3,952	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.269541	3,477	937	90.00
91.00	09100	EMERGENCY	0.149101	1,319,470	196,734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.562124	83,375	46,867	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)		11,603,304	1,577,481	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)		11,603,304		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112878	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.115748	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082794	25,824	2,138	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.227294	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.076643	273,961	20,997	60.00
65.00	06500	RESPIRATORY THERAPY	0.305644	535,041	163,532	65.00
66.00	06600	PHYSICAL THERAPY	0.254734	1,985,298	505,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.083061	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.592748	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047520	3,292	156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023404	326,513	7,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.162473	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235861	506,177	119,387	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.382944	0	0	76.01
76.03	03953	WOUND CARE	1.558173	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.269541	0	0	90.00
91.00	09100	EMERGENCY	0.149101	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.562124	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)		3,656,106	819,575	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)		3,656,106		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 3/2/2020 11:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		240,679		30.00
31.00	03100	INTENSIVE CARE UNIT		10,060		31.00
43.00	04300	NURSERY		64,838		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112878	249,208	28,130	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.115748	37,905	42,292	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082794	117,916	9,763	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.227294	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.076643	235,070	18,016	60.00
65.00	06500	RESPIRATORY THERAPY	0.305644	47,189	14,423	65.00
66.00	06600	PHYSICAL THERAPY	0.254734	4,591	1,169	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.083061	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.592748	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047520	29,886	1,420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023404	118,659	2,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.162473	8,064	1,310	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235861	106,293	25,070	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.382944	0	0	76.01
76.03	03953	WOUND CARE	1.558173	1,481	2,308	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.269541	1,376	371	90.00
91.00	09100	EMERGENCY	0.149101	83,513	12,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.562124	13,875	7,799	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)		1,055,026	167,300	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,055,026		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,369,882	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	62,842	2.04
3.00	Managed Care Simulated Payments	1,206,996	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	52.89	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.01	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.44	31.00
32.00	Sum of lines 30 and 31	17.45	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.09	33.00
34.00	Disproportionate share adjustment (see instructions)	24,232	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part A Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000040259	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	333,058	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	333,058	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	333,058		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,790,014		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		2,790,014	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		199,258	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		2,989,272	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,989,272	61.00
62.00	Deductibles billed to program beneficiaries		401,632	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		22,268	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		14,474	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,435	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,602,114	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		10,459	70.93
70.94	HRR adjustment amount (see instructions)		-27,254	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	486,435	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,071,754	71.00
71.01	Sequestration adjustment (see instructions)		61,435	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		2,895,489	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		114,830	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		327,361	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		1.0080897677	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.9842	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,369,882	0		2,369,882	2,369,882	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	62,842	0		62,842	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,206,996	0	0	1,206,996	1,206,996	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0409	0.0409	0.0409	0.0409		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	24,232	0	0	24,232	24,232	11.00
11.01	Uncompensated care payments	36.00	333,058	0	0	333,058	333,058	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,790,014	0	0	2,790,014	2,790,014	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,790,014	0	0	2,790,014	2,790,014	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	199,258	0	0	199,258	199,258	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	2,989,272	2,989,272	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	191,399	0	0	191,399	191,399	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	7,859	0	0	7,859	7,859	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	199,258	0	0	199,258	199,258	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.162727		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				486,435	486,435	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,604	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,131,098	2.00
3.00	OPPS payments	2,573,163	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)	4,604	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	19,465	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)	19,465	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)	19,465	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	14,861	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)	4,604	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)	2,573,163	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	2,203	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	524,443	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,051,121	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,051,121	30.00
31.00	Primary payer payments	1,334	31.00
32.00	Subtotal (line 30 minus line 31)	2,049,787	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)	56,288	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	36,587	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,137	36.00
37.00	Subtotal (see instructions)	2,086,374	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-52	38.00
39.00	OTHER ADJUSTMENTS PS&R	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,086,426	40.00
40.01	Sequestration adjustment (see instructions)	41,729	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,007,553	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	37,144	43.00
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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	517	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	517	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,190	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)	2,190	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)	2,190	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,673	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)	517	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)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		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)	517	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)	517	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	517	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	517	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	517	40.00
40.01	Sequestration adjustment (see instructions)	10	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	429	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	78	43.00
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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,895,489		2,007,553	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)		2,895,489		2,007,553	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		114,830		37,144	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,010,319		2,044,697	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: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I | Date/Time Prepared: 3/2/2020 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		637,983		429	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)		637,983		429	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		78	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		637,983		507	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: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VI Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	728,319	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	728,319	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	77,316	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	651,003	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	ROUNDING	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	651,003	15.00
15.01	Sequestration adjustment (see instructions)	13,020	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	637,983	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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

Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G | Date/Time Prepared: 3/2/2020 11:09 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-261,707	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,089,235	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,343,664	0	0	0	6.00
7.00	Inventory	1,069,199	0	0	0	7.00
8.00	Prepaid expenses	355,181	0	0	0	8.00
9.00	Other current assets	12,353	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)	8,920,597	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,844,900	0	0	0	12.00
13.00	Land improvements	719,024	0	0	0	13.00
14.00	Accumulated depreciation	-536,580	0	0	0	14.00
15.00	Buildings	20,284,298	0	0	0	15.00
16.00	Accumulated depreciation	-11,095,619	0	0	0	16.00
17.00	Leasehold improvements	7,968,152	0	0	0	17.00
18.00	Accumulated depreciation	-4,053,295	0	0	0	18.00
19.00	Fixed equipment	3,900,057	0	0	0	19.00
20.00	Accumulated depreciation	-3,290,389	0	0	0	20.00
21.00	Automobiles and trucks	47,177	0	0	0	21.00
22.00	Accumulated depreciation	-40,934	0	0	0	22.00
23.00	Major movable equipment	13,004,754	0	0	0	23.00
24.00	Accumulated depreciation	-9,013,994	0	0	0	24.00
25.00	Minor equipment depreciable	6,456,966	0	0	0	25.00
26.00	Accumulated depreciation	-3,315,022	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)	24,879,495	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	7,725,721	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,725,721	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,525,813	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,153,902	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,370,235	0	0	0	38.00
39.00	Payroll taxes payable	134,931	0	0	0	39.00
40.00	Notes and loans payable (short term)	210,417	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	41,503,749	0	0	0	43.00
44.00	Other current liabilities	220,813	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	44,594,047	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	374,593	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	374,593	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,968,640	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-3,442,827				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)	-3,442,827	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,525,813	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-1 | Date/Time Prepared: 3/2/2020 11:09 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,022,152		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,636,334				2.00
3.00	Total (sum of line 1 and line 2)		-4,614,182		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)		-4,614,182		0		11.00
12.00	PLUG TO RE	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)		-4,614,182		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	PLUG TO RE		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: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 3/2/2020 11:09 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,583,620		12,583,620	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	3,878,146		3,878,146	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)	16,461,766		16,461,766	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,537,660		1,537,660	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)	1,537,660		1,537,660	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,999,426		17,999,426	17.00
18.00	Ancillary services	38,218,111	115,903,479	154,121,590	18.00
19.00	Outpatient services	3,554,932	17,934,985	21,489,917	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	59,772,469	133,838,464	193,610,933	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,917,010		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)		39,917,010		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-3 | Date/Time Prepared: 3/2/2020 11:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	193,610,933	1.00
2.00	Less contractual allowances and discounts on patients' accounts	159,402,003	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,208,930	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,917,010	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,708,080	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	71,746	24.00
25.00	Total other income (sum of lines 6-24)	71,746	25.00
26.00	Total (line 5 plus line 25)	-5,636,334	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)	-5,636,334	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0075	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 3/2/2020 11:09 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	191,399	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	7,859	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	9.88	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	199,258	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00