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: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/10/2020 2:50 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/10/2020 Time: 2:50 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN HOSPITAL (15-0042) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) THOMAS COOK
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	42,229	214,334	0	-605,521	1.00
2.00	Subprovider - IPF	0	426,478	278		182,998	2.00
3.00	Subprovider - IRF	0	25,293	-15		-30,575	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	494,000	214,597	0	-453,098	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 7/10/2020 2:50 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 520 SOUTH 7TH STREET	PO Box:			1.00
2.00	City: VINCENNES	State: IN	Zip Code: 47591	County: KNOX	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	GOOD SAMARITAN HOSPITAL	150042	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	GOOD SAMARITAN HOSPITAL	15S042	99915	4	01/01/1984	N	P	O	4.00
5.00	Subprovider - IRF	GOOD SAMARITAN - REHAB	15T042	99915	5	01/01/2001	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GOOD SAMARITAN HOME CENTER	157432	99915		06/27/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GOOD SAMARITAN LINCOLN TRAIL HOSPICE	151526	99915		01/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	9		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)	Y	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	456	1,281	314	110	684	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	42	75	0	61	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	06/03/2019	12/31/2019	38.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	Y	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.	Y	N		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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	Y	N		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 7/10/2020 2:50 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.02

		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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/10/2020 2:50 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	379,378	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 7/10/2020 2:50 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		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.	Y		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.	Y		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	03/27/2020	N	03/27/2020	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 7/10/2020 2:50 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO, LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/10/2020 2:50 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	69	25,185	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)		69	25,185	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	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)		99	36,135	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		144				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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,668	395	11,421			1.00
2.00	HMO and other (see instructions)	1,886	2,325				2.00
3.00	HMO IPF Subprovider	174	1,492				3.00
4.00	HMO IRF Subprovider	219	136				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)	6,668	395	11,421			7.00
8.00	INTENSIVE CARE UNIT	3,997	0	6,570			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		60	843			13.00
14.00	Total (see instructions)	10,665	455	18,834	0.00	1,475.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,438	288	4,502	2.02	31.73	16.00
17.00	SUBPROVIDER - IRF	5,957	42	7,059	0.00	33.32	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	7.51	24.00
24.10	HOSPICE (non-distinct part)			527			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)				2.02	1,547.56	27.00
28.00	Observation Bed Days		615	3,280			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	65	125			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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,895	96	5,356	1.00
2.00	HMO and other (see instructions)			467	652		2.00
3.00	HMO IPF Subprovider				286		3.00
4.00	HMO IRF Subprovider				6		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	2,895	96	5,356	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	193	56	830	16.00
17.00	SUBPROVIDER - IRF	0.00	0	425	3	491	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II | Date/Time Prepared: 7/10/2020 2:50 pm

		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	102,615,860	0	102,615,860	3,219,387.15	31.87	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		208,638	0	208,638	790.00	264.10	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		4,774,944	0	4,774,944	22,933.00	208.21	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)		254,224	0	254,224	6,160.00	41.27	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		35,651,532	0	35,651,532	873,515.00	40.81	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		381,084	0	381,084	7,195.00	52.97	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		568,213	0	568,213	7,664.00	74.14	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		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		19,964,589	0	19,964,589			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		7,480,682	0	7,480,682			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		18,794	0	18,794			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		480,794	0	480,794			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)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II | Date/Time Prepared: 7/10/2020 2:50 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	5,281,115	0	5,281,115	282,723.00	18.68	26.00
27.00	Administrative & General	5.00	8,365,059	0	8,365,059	252,125.00	33.18	27.00
28.00	Administrative & General under contract (see inst.)		378,063	0	378,063	3,303.00	114.46	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,254,007	0	2,254,007	94,701.00	23.80	30.00
31.00	Laundry & Linen Service	8.00	210,259	0	210,259	15,183.00	13.85	31.00
32.00	Housekeeping	9.00	2,003,398	0	2,003,398	134,396.00	14.91	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,613,478	-1,169,359	444,119	28,294.00	15.70	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,169,359	1,169,359	74,496.00	15.70	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,361,231	0	1,361,231	29,585.00	46.01	38.00
39.00	Central Services and Supply	14.00	370,879	0	370,879	22,536.00	16.46	39.00
40.00	Pharmacy	15.00	2,850,451	0	2,850,451	71,728.00	39.74	40.00
41.00	Medical Records & Medical Records Library	16.00	2,503,142	0	2,503,142	103,617.00	24.16	41.00
42.00	Social Service	17.00	505,008	0	505,008	16,612.00	30.40	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 7/10/2020 2:50 pm

		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)		97,964,755	0	97,964,755	3,193,597.15	30.68	1.00
2.00	Excluded area salaries (see instructions)		35,651,532	0	35,651,532	873,515.00	40.81	2.00
3.00	Subtotal salaries (line 1 minus line 2)		62,313,223	0	62,313,223	2,320,082.15	26.86	3.00
4.00	Subtotal other wages & related costs (see inst.)		949,297	0	949,297	14,859.00	63.89	4.00
5.00	Subtotal wage-related costs (see inst.)		19,983,383	0	19,983,383	0.00	32.07	5.00
6.00	Total (sum of lines 3 thru 5)		83,245,903	0	83,245,903	2,334,941.15	35.65	6.00
7.00	Total overhead cost (see instructions)		27,696,090	0	27,696,090	1,129,299.00	24.53	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part IV Date/Time Prepared: 7/10/2020 2:50 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,701,077	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)	14,793,471	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	321,514	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	149,087	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	335,927	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	6,799,750	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	38,706	19.00
20.00	State or Federal Unemployment Taxes	0	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	52,251	22.00
23.00	Tuition Reimbursement	218,664	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27,410,447	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part V Date/Time Prepared: 7/10/2020 2:50 pm

	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	381,084	27,410,447	1.00
2.00	Hospital	381,084	27,410,447	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0042 Hospice CCN: 15-1526

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

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	6,077	129	162	6,368	11.00
12.00	Hospice Inpatient Respite Care	22	0	31	53	12.00
13.00	Hospice General Inpatient Care	384	10	86	480	13.00
14.00	Total Hospice Days	6,483	139	279	6,901	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 7/10/2020 2:50 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.236496	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,262,943	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	80,916,086	6.00
7.00	Medicaid cost (line 1 times line 6)	19,136,331	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)	7,873,388	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)	7,873,388	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)	8,432,838	2,271,598	10,704,436	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,994,332	2,271,598	4,265,930	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)	1,994,332	2,271,598	4,265,930	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)	16,613,777	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	760,007	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,169,242	27.01
28.00	Non-Medicare bad debt expense (see instructions)	15,444,535	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	4,061,806	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	8,327,736	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	16,201,124	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		19,057,699	19,057,699	6,095,688	25,153,387	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		21,758	21,758	0	21,758	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	653,390	1,581,276	2,234,666	26,271,913	28,506,579	4.00
4.01	00401	COMMUNICATIONS	279,672	83,842	363,514	-82,442	281,072	4.01
4.02	00402	PURCHASING & RECEIVING	624,086	539,966	1,164,052	-259,620	904,432	4.02
4.03	00403	REGISTRATION	1,377,517	467,311	1,844,828	-444,666	1,400,162	4.03
4.04	00404	PATIENT ACCOUNTS	2,346,450	1,741,512	4,087,962	-398,733	3,689,229	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	8,365,059	24,296,537	32,661,596	-2,556,637	30,104,959	5.00
7.00	00700	OPERATION OF PLANT	2,254,007	4,352,879	6,606,886	-675,430	5,931,456	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210,259	177,185	387,444	-97,338	290,106	8.00
9.00	00900	HOUSEKEEPING	2,003,398	969,840	2,973,238	-757,166	2,216,072	9.00
10.00	01000	DIETARY	1,613,478	1,978,365	3,591,843	-2,762,401	829,442	10.00
11.00	01100	CAFETERIA	0	0	0	2,214,828	2,214,828	11.00
13.00	01300	NURSING ADMINISTRATION	1,361,231	540,110	1,901,341	-300,629	1,600,712	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	370,879	291,894	662,773	-78,347	584,426	14.00
15.00	01500	PHARMACY	2,850,451	18,618,088	21,468,539	-18,307,460	3,161,079	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,503,142	1,359,828	3,862,970	-803,172	3,059,798	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	505,008	350,571	855,579	-125,380	730,199	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	254,224	254,224	0	254,224	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	816,358	556,745	1,373,103	-215,062	1,158,041	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	111,300	37,719	149,019	-32,844	116,175	23.00
23.01	02301	PARAMED ED PRGM-LAB	230,594	67,509	298,103	-55,473	242,630	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,222,643	1,615,573	5,838,216	-883,945	4,954,271	30.00
31.00	03100	INTENSIVE CARE UNIT	3,327,354	1,321,432	4,648,786	-933,466	3,715,320	31.00
40.00	04000	SUBPROVIDER - IPF	1,928,648	563,178	2,491,826	-423,865	2,067,961	40.00
41.00	04100	SUBPROVIDER - IRF	1,684,195	610,373	2,294,568	-502,372	1,792,196	41.00
43.00	04300	NURSERY	253,202	88,593	341,795	-67,517	274,278	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,210,829	5,440,191	8,651,020	-3,676,478	4,974,542	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	982,771	1,140,568	2,123,339	-486,573	1,636,766	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,171,076	363,072	1,534,148	-539,110	995,038	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,675,309	3,609,226	7,284,535	-1,801,497	5,483,038	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,517,144	1,722,961	4,240,105	-586,174	3,653,931	55.00
60.00	06000	LABORATORY	2,306,141	5,059,076	7,365,217	-658,519	6,706,698	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,203,973	1,778,168	3,982,141	-818,555	3,163,586	65.00
66.00	06600	PHYSICAL THERAPY	3,653,980	1,086,672	4,740,652	-985,105	3,755,547	66.00
69.00	06900	ELECTROCARDIOLOGY	5,350,054	3,512,785	8,862,839	-2,828,895	6,033,944	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	391,626	302,712	694,338	-90,338	604,000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,258,628	4,258,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,879,217	5,879,217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,624,491	17,624,491	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,187,873	2,079,322	3,267,195	-1,392,237	1,874,958	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	656,192	656,192	-5,576	650,616	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	122,981	27,038	150,019	-24,965	125,054	90.00
90.01	04950	WOUND CLINIC	407,558	3,622,017	4,029,575	-2,989,413	1,040,162	90.01
91.00	09100	EMERGENCY	3,746,603	2,919,473	6,666,076	-961,572	5,704,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	98,826	93,598	192,424	-18,125	174,299	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		6,140,006	6,140,006	-6,140,006	0	113.00
116.00	11600	HOSPICE	441,450	797,623	1,239,073	-102,777	1,136,296	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,360,515	121,894,707	193,255,222	7,474,885	200,730,107	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,546,214	15,124,677	37,670,891	-5,084,540	32,586,351	192.00
192.01	19201	FP PETERSBURG	265,754	138,122	403,876	-50,195	353,681	192.01
192.02	19202	PEDIATRICS	1,417,461	908,154	2,325,615	-380,849	1,944,766	192.02
192.03	19203	WASHINGTON PRIMARY CARE	1,192,973	593,532	1,786,505	-335,724	1,450,781	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	12,652	12,652	0	12,652	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	178,524	387,787	566,311	-47,783	518,528	194.02
194.03	07953	MH RESIDENTIAL	432,856	155,933	588,789	-117,361	471,428	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	35,278	35,278	0	35,278	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	5,221,563	2,149,725	7,371,288	-1,458,433	5,912,855	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	102,615,860	141,400,567	244,016,427	0	244,016,427	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,195,592	23,957,795		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	21,758		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-18,005	28,488,574		4.00
4.01	00401	COMMUNICATIONS	0	281,072		4.01
4.02	00402	PURCHASING & RECEIVING	-362,893	541,539		4.02
4.03	00403	REGISTRATION	0	1,400,162		4.03
4.04	00404	PATIENT ACCOUNTS	-85,664	3,603,565		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-13,346,455	16,758,504		5.00
7.00	00700	OPERATION OF PLANT	-33,000	5,898,456		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-14,262	275,844		8.00
9.00	00900	HOUSEKEEPING	-34,000	2,182,072		9.00
10.00	01000	DIETARY	0	829,442		10.00
11.00	01100	CAFETERIA	-1,129,297	1,085,531		11.00
13.00	01300	NURSING ADMINISTRATION	-3,228	1,597,484		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	584,426		14.00
15.00	01500	PHARMACY	-11,243	3,149,836		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-72,673	2,987,125		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
17.01	01701	MENTAL HEALTH OH	-49,591	680,608		17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	-91	254,133		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	200,000	1,358,041		22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	-13,598	102,577		23.00
23.01	02301	PARAMED ED PRGM-LAB	-18,106	224,524		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-80	4,954,191		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,715,320		31.00
40.00	04000	SUBPROVIDER - IPF	-390,263	1,677,698		40.00
41.00	04100	SUBPROVIDER - IRF	0	1,792,196		41.00
43.00	04300	NURSERY	0	274,278		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,817,645	3,156,897		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	-6,280	1,630,486		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	995,038		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,574	5,481,464		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,420,618	2,233,313		55.00
60.00	06000	LABORATORY	-1,311	6,705,387		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	-1,031,699	2,131,887		65.00
66.00	06600	PHYSICAL THERAPY	-915	3,754,632		66.00
69.00	06900	ELECTROCARDIOLOGY	-3,569,579	2,464,365		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	-30	603,970		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-590	4,258,038		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,879,217		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-388,398	17,236,093		73.00
75.00	07500	ASC (NON-DISTINCT PART)	-47,276	1,827,682		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	-199,297	451,319		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-180	124,874		90.00
90.01	04950	WOUND CLINIC	0	1,040,162		90.01
91.00	09100	EMERGENCY	-1,331,318	4,373,186		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	174,299		96.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	1,136,296		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-26,394,751	174,335,356		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,586,351		192.00
192.01	19201	FP PETERSBURG	0	353,681		192.01
192.02	19202	PEDIATRICS	0	1,944,766		192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,450,781		192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	12,652		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	518,528		194.02
194.03	07953	MH RESIDENTIAL	0	471,428		194.03
194.04	07954	UNUSED SPACE	0	0		194.04
194.05	07955	MOB	0	35,278		194.05

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.06	07956	FOUNDATION	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	5,912,855		194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-26,394,751	217,621,676		200.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 7/10/2020 2:50 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,624,491	1.00
	0		0	17,624,491	
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,258,628	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,879,217	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	49,927	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
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
	0		0	10,187,772	
	C - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26,315,707	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
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
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 7/10/2020 2:50 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
	0		0	26,315,707		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,762,064		1.00
2.00	PATIENT ACCOUNTS	4.04	0	377,942		2.00
	0		0	6,140,006		
	E - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	333,624		1.00
	0		0	333,624		
	F - DIETARY RECLASS					
1.00	CAFETERIA	11.00	1,169,359	1,045,469		1.00
	0		1,169,359	1,045,469		
	G - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	257,637	24,143		1.00
	TOTALS		257,637	24,143		
500.00	Grand Total: Increases		1,426,996	61,671,212		500.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 7/10/2020 2:50 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	17,624,491	0		1.00
	0		0	17,624,491			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43,794	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	1,468	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	539	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1,348	0		4.00
5.00	HOUSEKEEPING	9.00	0	50	0		5.00
6.00	DIETARY	10.00	0	11,742	0		6.00
7.00	PHARMACY	15.00	0	14,024	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	30,876	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	53,243	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	1,161	0		10.00
11.00	SUBPROVIDER - IRF	41.00	0	8,286	0		11.00
12.00	NURSERY	43.00	0	5,963	0		12.00
13.00	OPERATING ROOM	50.00	0	2,848,953	0		13.00
14.00	ENDOSCOPY	51.01	0	248,835	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	13,260	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	823,064	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	8,129	0		17.00
18.00	LABORATORY	60.00	0	3,444	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	206,120	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	17,518	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	1,787,643	0		21.00
22.00	NEURODIAGNOSTICS	70.01	0	1,455	0		22.00
23.00	ASC (NON-DISTINCT PART)	75.00	0	1,059,003	0		23.00
24.00	INPATIENT DIALYSIS	76.01	0	5,576	0		24.00
25.00	WOUND CLINIC	90.01	0	2,907,721	0		25.00
26.00	EMERGENCY	91.00	0	84,557	0		26.00
	0		0	10,187,772			
	C - EMPLOYEE BENEFITS						
1.00	COMMUNICATIONS	4.01	0	82,442	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	258,152	0		2.00
3.00	REGISTRATION	4.03	0	444,666	0		3.00
4.00	PATIENT ACCOUNTS	4.04	0	776,675	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	2,222,474	0		5.00
6.00	OPERATION OF PLANT	7.00	0	674,082	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	97,338	0		7.00
8.00	HOUSEKEEPING	9.00	0	757,116	0		8.00
9.00	DIETARY	10.00	0	535,831	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	300,629	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	128,274	0		11.00
12.00	PHARMACY	15.00	0	668,945	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	803,172	0		13.00
14.00	MENTAL HEALTH OH	17.01	0	125,380	0		14.00
16.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	215,062	0		16.00
17.00	PARAMED ED PRGM-RADIOLOGY	23.00	0	32,844	0		17.00
18.00	PARAMED ED PRGM-LAB	23.01	0	55,473	0		18.00
19.00	ADULTS & PEDIATRICS	30.00	0	1,134,849	0		19.00
20.00	INTENSIVE CARE UNIT	31.00	0	880,223	0		20.00
21.00	SUBPROVIDER - IPF	40.00	0	422,704	0		21.00
22.00	SUBPROVIDER - IRF	41.00	0	494,086	0		22.00
23.00	NURSERY	43.00	0	61,554	0		23.00
24.00	OPERATING ROOM	50.00	0	827,525	0		24.00
25.00	ENDOSCOPY	51.01	0	237,738	0		25.00
26.00	DELIVERY ROOM & LABOR ROOM	52.00	0	244,070	0		26.00
27.00	RADIOLOGY-DIAGNOSTIC	54.00	0	978,433	0		27.00
28.00	RADIOLOGY-THERAPEUTIC	55.00	0	578,045	0		28.00
29.00	LABORATORY	60.00	0	655,075	0		29.00
30.00	RESPIRATORY THERAPY	65.00	0	612,435	0		30.00
31.00	PHYSICAL THERAPY	66.00	0	967,587	0		31.00
32.00	ELECTROCARDIOLOGY	69.00	0	1,041,252	0		32.00
33.00	NEURODIAGNOSTICS	70.01	0	88,883	0		33.00
34.00	ASC (NON-DISTINCT PART)	75.00	0	333,234	0		34.00
35.00	CLINIC	90.00	0	24,965	0		35.00
36.00	WOUND CLINIC	90.01	0	81,692	0		36.00
37.00	EMERGENCY	91.00	0	877,015	0		37.00
38.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	18,125	0		38.00
39.00	HOSPICE	116.00	0	102,777	0		39.00
40.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,084,540	0		40.00
41.00	FP PETERSBURG	192.01	0	50,195	0		41.00
42.00	PEDIATRICS	192.02	0	380,849	0		42.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 7/10/2020 2:50 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
43.00	WASHINGTON PRIMARY CARE	192.03	0	335,724	0		43.00
44.00	MARKETING AND PUBLIC RELATIONS	194.02	0	47,783	0		44.00
45.00	MH RESIDENTIAL	194.03	0	117,361	0		45.00
46.00	COMMUNITY MENTAL HEALTH CENTER	194.09	0	1,458,433	0		46.00
	0		0	26,315,707			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	6,140,006	11		1.00
2.00		0.00	0	0	0		2.00
	0		0	6,140,006			
	E - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	333,624	12		1.00
	0		0	333,624			
	F - DIETARY RECLASS						
1.00	DIETARY	10.00	1,169,359	1,045,469	0		1.00
	0		1,169,359	1,045,469			
	G - OB RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	257,637	24,143	0		1.00
	TOTALS		257,637	24,143			
500.00	Grand Total: Decreases		1,426,996	61,671,212			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,781,448	0	0	0	200,000	1.00
2.00	Land Improvements	10,676,928	13,697	0	13,697	81,343	2.00
3.00	Buildings and Fixtures	161,037,809	2,908,752	0	2,908,752	128,369	3.00
4.00	Building Improvements	862,950	2,521	0	2,521	14,909	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	217,250,999	8,084,375	0	8,084,375	6,890,059	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	396,610,134	11,009,345	0	11,009,345	7,314,680	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	396,610,134	11,009,345	0	11,009,345	7,314,680	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,581,448	0	1.00
2.00	Land Improvements	10,609,282	0	2.00
3.00	Buildings and Fixtures	163,818,192	0	3.00
4.00	Building Improvements	850,562	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	218,445,315	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	400,304,799	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	400,304,799	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 7/10/2020 2:50 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	19,057,699	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	18,198	3,560	0	2.00
3.00	Total (sum of lines 1-2)	19,057,699	0	18,198	3,560	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	19,057,699	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	21,758	2.00
3.00	Total (sum of lines 1-2)	0	19,079,457	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 7/10/2020 2:50 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	181,859,484	0	181,859,484	0.454303	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	218,445,315	0	218,445,315	0.545697	0	2.00
3.00	Total (sum of lines 1-2)	400,304,799	0	400,304,799	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	19,057,699	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,057,699	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	4,566,472	333,624	0	0	23,957,795	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,198	3,560	0	0	21,758	2.00
3.00	Total (sum of lines 1-2)	4,584,670	337,184	0	0	23,979,553	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 7/10/2020 2:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,465	PURCHASING & RECEIVING	4.02	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)	B	-29,028	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,424,151			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-487,137	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	B	-388,398	DRUGS CHARGED TO PATIENTS	73.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-1,215	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 7/10/2020 2:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-361,428	PURCHASING & RECEIVING	4.02	0	33.01
33.02	MISC INCOME	B	-7,221	PATIENT ACCOUNTS	4.04	0	33.02
33.03	MISC INCOME	B	-1,355,127	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC INCOME	B	-3,972	OPERATION OF PLANT	7.00	0	33.04
33.05	MISC INCOME	B	-14,262	LAUNDRY & LINEN SERVICE	8.00	0	33.05
33.06	MISC INCOME	B	-34,000	HOUSEKEEPING	9.00	0	33.06
33.07	MISC INCOME	B	-2,041	PHARMACY	15.00	0	33.07
33.08	MISC INCOME	B	-72,673	MEDICAL RECORDS & LIBRARY	16.00	0	33.08
33.09	MISC INCOME	B	-49,591	MENTAL HEALTH OH	17.01	0	33.09
33.10	MISC INCOME	B	-13,598	PARAMED ED PRGM-RADIOLOGY	23.00	0	33.10
33.11	MISC INCOME	B	-18,106	PARAMED ED PRGM-LAB	23.01	0	33.11
33.12	MISC INCOME	B	-6,280	ENDOSCOPY	51.01	0	33.12
33.13	MISC INCOME	B	-111	LABORATORY	60.00	0	33.13
33.14	MISC INCOME	B	-299	PHYSICAL THERAPY	66.00	0	33.14
33.15	MISC INCOME	B	-120,192	ELECTROCARDIOLOGY	69.00	0	33.15
33.16	MISC INCOME	B	-590	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.16
33.17	MISC INCOME	B	-354	ASC (NON-DISTINCT PART)	75.00	0	33.17
33.18	MISC INCOME	B	-180	CLINIC	90.00	0	33.18
33.19	OTHER MISC FEES	B	-642,160	CAFETERIA	11.00	0	33.19
33.20	PROVIDER ASSESSMENT FEE	A	-11,838,968	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	GME CONSORTIUM FEES	A	200,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.21
33.22	INTEREST INCOME	B	-1,195,592	CAP REL COSTS-BLDG & FIXT	1.00	11	33.22
33.23	PHYSICIAN BILLING COSTS	A	-78,443	PATIENT ACCOUNTS	4.04	0	33.23
33.24	DONATIONS EXPENSE	A	-53,537	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	ADVERTISING	A	-596	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	ADVERTISING	A	-30	NURSING ADMINISTRATION	13.00	0	33.26
33.27	ADVERTISING	A	-91	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	33.27
33.28	ADVERTISING	A	-80	ADULTS & PEDIATRICS	30.00	0	33.28
33.29	ADVERTISING	A	-590	RADIOLOGY-DIAGNOSTIC	54.00	0	33.29
33.30	ADVERTISING	A	-616	PHYSICAL THERAPY	66.00	0	33.30
33.31	ADVERTISING	A	-2,719	ELECTROCARDIOLOGY	69.00	0	33.31
33.32	ADVERTISING	A	-30	NEURODIAGNOSTICS	70.01	0	33.32
33.33	2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	AHA LOBBYING OFFSET	A	-9,020	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	IHA LOBBYING OFFSET	A	-5,323	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	INDIANA CHAMBER LOBBYING OFFSET	A	-151	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	RENTAL	B	-25,674	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	RENTAL	B	-19,620	OPERATING ROOM	50.00	0	33.38
33.39	RENTAL	B	-1,200	ELECTROCARDIOLOGY	69.00	0	33.39
33.40	RENTAL	B	-193,462	INPATIENT DIALYSIS	76.01	0	33.40
33.41	MISC INCOME	B	-27,636	OPERATING ROOM	50.00	0	33.41
33.42	PHYSICIAN LOAN EXPENSE	A	-92,649	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	PHYSICIAN LOAN EXPENSE	A	-6,000	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	PHYSICIAN LOAN EXPENSE	A	-10,000	OPERATING ROOM	50.00	0	33.44
33.45	PHYSICIAN LOAN EXPENSE	A	-20,000	RADIOLOGY-THERAPEUTIC	55.00	0	33.45
33.46	PHYSICIAN LOAN EXPENSE	A	-20,000	ELECTROCARDIOLOGY	69.00	0	33.46
33.47	IHRA LOBBYING OFF	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	0	33.47
33.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.48
33.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.49
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,394,751				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 7/10/2020 2:50 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	16,790	16,790	0	211,500	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	194,265	265	194,000	211,500	2,728	2.00
3.00	13.00	NURSING ADMINISTRATION	15,400	0	15,400	211,500	120	3.00
4.00	15.00	PHARMACY	12,252	0	12,252	211,500	30	4.00
5.00	40.00	SUBPROVIDER - IPF	414,667	357,503	57,164	211,500	240	5.00
6.00	50.00	OPERATING ROOM	1,771,524	1,757,424	14,100	246,400	94	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	984	984	0	271,900	0	7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	1,430,292	1,390,567	39,725	271,900	227	8.00
9.00	60.00	LABORATORY	135,851	1,200	134,651	211,500	2,813	9.00
10.00	65.00	RESPIRATORY THERAPY	1,049,699	1,031,699	18,000	271,900	300	10.00
11.00	69.00	ELECTROCARDIOLOGY	3,478,343	3,279,745	198,598	211,500	520	11.00
12.00	70.01	NEURODIAGNOSTICS	18,000	0	18,000	211,500	331	12.00
13.00	75.00	ASC (NON-DISTINCT PART)	76,207	45,870	30,337	211,500	288	13.00
14.00	76.01	INPATIENT DIALYSIS	40,000	0	40,000	211,500	336	14.00
15.00	91.00	EMERGENCY	1,409,614	1,329,783	79,831	211,500	770	15.00
200.00			10,063,888	9,211,830	852,058		8,797	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	277,390	13,870	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	12,202	610	0	0	0	3.00
4.00	15.00	PHARMACY	3,050	153	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	24,404	1,220	0	0	0	5.00
6.00	50.00	OPERATING ROOM	11,135	557	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	29,674	1,484	0	0	0	8.00
9.00	60.00	LABORATORY	286,033	14,302	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	39,216	1,961	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	52,875	2,644	0	0	0	11.00
12.00	70.01	NEURODIAGNOSTICS	33,657	1,683	0	0	0	12.00
13.00	75.00	ASC (NON-DISTINCT PART)	29,285	1,464	0	0	0	13.00
14.00	76.01	INPATIENT DIALYSIS	34,165	1,708	0	0	0	14.00
15.00	91.00	EMERGENCY	78,296	3,915	0	0	0	15.00
200.00			911,382	45,571	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	16,790		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	277,390	0	265		2.00
3.00	13.00	NURSING ADMINISTRATION	0	12,202	3,198	3,198		3.00
4.00	15.00	PHARMACY	0	3,050	9,202	9,202		4.00
5.00	40.00	SUBPROVIDER - IPF	0	24,404	32,760	390,263		5.00
6.00	50.00	OPERATING ROOM	0	11,135	2,965	1,760,389		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	984		7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	0	29,674	10,051	1,400,618		8.00
9.00	60.00	LABORATORY	0	286,033	0	1,200		9.00
10.00	65.00	RESPIRATORY THERAPY	0	39,216	0	1,031,699		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	52,875	145,723	3,425,468		11.00
12.00	70.01	NEURODIAGNOSTICS	0	33,657	0	0		12.00
13.00	75.00	ASC (NON-DISTINCT PART)	0	29,285	1,052	46,922		13.00
14.00	76.01	INPATIENT DIALYSIS	0	34,165	5,835	5,835		14.00
15.00	91.00	EMERGENCY	0	78,296	1,535	1,331,318		15.00
200.00			0	911,382	212,321	9,424,151		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	23,957,795	23,957,795				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	21,758		21,758			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	28,488,574	124,967	110	28,613,651		4.00
4.01	00401	COMMUNICATIONS	281,072	0	0	78,484	359,556	4.01
4.02	00402	PURCHASING & RECEIVING	541,539	431,966	377	175,137	3,155	4.02
4.03	00403	REGISTRATION	1,400,162	0	0	386,571	5,813	4.03
4.04	00404	PATIENT ACCOUNTS	3,603,565	0	0	658,482	7,141	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	16,758,504	1,172,069	1,140	2,347,478	26,406	5.00
7.00	00700	OPERATION OF PLANT	5,898,456	3,633,696	3,432	632,540	21,922	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	275,844	146,370	131	59,005	0	8.00
9.00	00900	HOUSEKEEPING	2,182,072	203,906	183	562,212	6,311	9.00
10.00	01000	DIETARY	829,442	0	0	124,633	4,318	10.00
11.00	01100	CAFETERIA	1,085,531	347,969	312	328,156	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,597,484	238,761	214	382,001	3,322	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	584,426	2,502	2	104,079	1,495	14.00
15.00	01500	PHARMACY	3,149,836	172,025	154	799,919	5,148	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,987,125	131,110	118	702,454	8,636	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	680,608	95,671	86	141,720	33,714	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	254,133	111,237	100	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,358,041	0	0	229,094	3,820	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	102,577	0	0	31,234	498	23.00
23.01	02301	PARAMED ED PRGM-LAB	224,524	0	0	64,711	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,954,191	1,941,414	1,743	1,257,296	26,074	30.00
31.00	03100	INTENSIVE CARE UNIT	3,715,320	743,161	667	933,752	15,943	31.00
40.00	04000	SUBPROVIDER - IPF	1,677,698	362,283	325	541,235	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,792,196	477,883	429	472,634	11,625	41.00
43.00	04300	NURSERY	274,278	0	0	71,056	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,156,897	525,469	472	901,052	23,915	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,630,486	340,130	305	275,794	4,152	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	995,038	0	0	256,337	10,961	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,481,464	917,187	824	1,031,398	9,965	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,233,313	213,940	192	706,384	6,145	55.00
60.00	06000	LABORATORY	6,705,387	201,182	181	647,170	5,314	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,131,887	157,849	142	618,499	6,311	65.00
66.00	06600	PHYSICAL THERAPY	3,754,632	613,163	551	1,025,413	4,982	66.00
69.00	06900	ELECTROCARDIOLOGY	2,464,365	505,345	454	1,501,380	12,954	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	603,970	212,495	191	109,902	3,322	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,258,038	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,879,217	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,236,093	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,827,682	0	0	333,352	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	451,319	238,539	214	0	498	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	124,874	74,158	67	34,512	1,329	90.00
90.01	04950	WOUND CLINIC	1,040,162	80,106	72	114,373	1,661	90.01
91.00	09100	EMERGENCY	4,373,186	482,053	433	1,051,405	16,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	174,299	10,951	10	27,733	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,136,296	110,375	99	123,884	3,820	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,335,356	15,019,932	13,730	19,842,471	297,610	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,586,351	3,203,289	2,877	6,327,145	54,140	192.00
192.01	19201	FP PETERSBURG	353,681	0	0	74,578	0	192.01
192.02	19202	PEDIATRICS	1,944,766	0	0	397,781	3,322	192.02
192.03	19203	WASHINGTON PRIMARY CARE	1,450,781	0	0	334,783	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
194.00	07950	COMMUNITY HEALTH SERVICES	12,652	70,489	63	0	3,322	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	518,528	52,450	47	50,099	830	194.02
194.03	07953	MH RESIDENTIAL	471,428	563,131	506	121,472	0	194.03
194.04	07954	UNUSED SPACE	0	3,221,106	2,893	0	0	194.04
194.05	07955	MOB	35,278	665,529	598	0	0	194.05
194.06	07956	FOUNDATION	0	12,953	12	0	332	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	130,971	118	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	5,912,855	1,017,945	914	1,465,322	0	194.09
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)	217,621,676	23,957,795	21,758	28,613,651	359,556	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING	1,152,174					4.02
4.03	00403	REGISTRATION	627	1,793,173				4.03
4.04	00404	PATIENT ACCOUNTS	562	0	4,269,750			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	20,740	0	0	20,326,337	20,326,337	5.00
7.00	00700	OPERATION OF PLANT	7,326	0	0	10,197,372	1,050,584	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,128	0	0	485,478	50,016	8.00
9.00	00900	HOUSEKEEPING	10,113	0	0	2,964,797	305,448	9.00
10.00	01000	DIETARY	75,738	0	0	1,034,131	106,541	10.00
11.00	01100	CAFETERIA	0	0	0	1,761,968	181,527	11.00
13.00	01300	NURSING ADMINISTRATION	448	0	0	2,222,230	228,945	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,766	0	0	697,270	71,836	14.00
15.00	01500	PHARMACY	3,007	0	0	4,130,089	425,502	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	267	0	0	3,829,710	394,556	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	68	0	0	951,867	98,066	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	365,470	37,653	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	520	0	0	1,591,475	163,962	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	2	0	0	134,311	13,837	23.00
23.01	02301	PARAMED ED PRGM-LAB	205	0	0	289,440	29,820	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,652	85,363	203,250	8,490,983	874,784	30.00
31.00	03100	INTENSIVE CARE UNIT	15,125	47,417	112,901	5,584,286	575,321	31.00
40.00	04000	SUBPROVIDER - IPF	1,065	22,827	54,351	2,659,784	274,024	40.00
41.00	04100	SUBPROVIDER - IRF	3,839	20,792	49,506	2,828,904	291,448	41.00
43.00	04300	NURSERY	844	3,292	7,838	357,308	36,812	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,554	120,902	287,871	5,047,132	519,981	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	28,616	30,447	72,496	2,382,426	245,449	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,547	13,588	32,353	1,311,824	135,151	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,561	255,987	609,677	8,318,063	856,968	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,184	66,175	157,565	3,387,898	349,038	55.00
60.00	06000	LABORATORY	134,682	191,307	455,506	8,340,729	859,304	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,594	38,848	92,498	3,050,628	314,291	65.00
66.00	06600	PHYSICAL THERAPY	1,691	68,587	163,307	5,632,326	580,270	66.00
69.00	06900	ELECTROCARDIOLOGY	5,886	108,420	258,150	4,856,954	500,388	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,134	15,530	36,977	983,521	101,327	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	235,827	13,355	31,798	4,539,018	467,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	321,449	34,981	83,290	6,318,937	651,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	236,334	562,716	18,035,143	1,858,071	73.00
75.00	07500	ASC (NON-DISTINCT PART)	19,399	64,946	154,638	2,400,017	247,262	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	109	3,923	9,342	703,944	72,524	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	92	454	1,081	236,567	24,372	90.00
90.01	04950	WOUND CLINIC	5,859	19,836	47,229	1,309,298	134,890	90.01
91.00	09100	EMERGENCY	16,445	142,835	340,094	6,423,391	661,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,247	1,301	3,097	218,638	22,525	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,094	9,238	21,997	1,406,803	144,936	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	999,012	1,616,685	3,849,528	155,806,467	13,957,839	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	120,009	154,060	366,820	42,814,691	4,410,969	192.00
192.01	19201	FP PETERSBURG	1,350	1,734	4,129	435,472	44,865	192.01
192.02	19202	PEDIATRICS	20,527	10,813	25,747	2,402,956	247,565	192.02
192.03	19203	WASHINGTON PRIMARY CARE	7,793	8,389	19,974	1,821,720	187,683	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	104	0	0	86,630	8,925	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	109	0	0	622,063	64,088	194.02
194.03	07953	MH RESIDENTIAL	1,143	1,492	3,552	1,162,724	119,790	194.03
194.04	07954	UNUSED SPACE	0	0	0	3,223,999	332,152	194.04
194.05	07955	MOB	0	0	0	701,405	72,262	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
194.06	07956	FOUNDATION	0	0	0	13,297	1,370	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	131,089	13,505	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	2,127	0	0	8,399,163	865,324	194.09
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)	1,152,174	1,793,173	4,269,750	217,621,676	20,326,337	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	11,247,956					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,537	624,031				8.00
9.00	00900	HOUSEKEEPING	123,340	41,619	3,435,204			9.00
10.00	01000	DIETARY	0	11,008	89,515	1,241,195		10.00
11.00	01100	CAFETERIA	210,482	0	21,278	0	2,175,255	11.00
13.00	01300	NURSING ADMINISTRATION	144,424	0	0	0	29,976	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,513	8,113	37,755	0	22,834	14.00
15.00	01500	PHARMACY	104,056	0	29,739	0	72,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,307	0	26,523	0	104,986	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	57,870	11,150	91,989	0	16,832	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	67,286	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	52,699	0	12,075	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	2,902	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	6,863	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,174,339	199,470	845,269	568,427	188,828	30.00
31.00	03100	INTENSIVE CARE UNIT	449,530	75,529	273,641	243,786	123,387	31.00
40.00	04000	SUBPROVIDER - IPF	219,141	0	0	167,051	67,247	40.00
41.00	04100	SUBPROVIDER - IRF	289,066	37,645	148,449	261,931	70,218	41.00
43.00	04300	NURSERY	0	1,446	9,253	0	8,050	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	317,850	22,787	190,757	0	76,127	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	205,741	18,158	50,522	0	31,317	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,682	12,222	0	28,352	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	554,796	43,051	163,986	0	115,941	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	129,410	0	0	0	53,313	55.00
60.00	06000	LABORATORY	121,693	0	47,801	0	105,209	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	95,481	122	36,271	0	64,680	65.00
66.00	06600	PHYSICAL THERAPY	370,895	8,396	91,395	0	117,929	66.00
69.00	06900	ELECTROCARDIOLOGY	305,677	13,044	141,967	0	96,742	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	128,535	8,836	36,815	0	14,945	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	22,257	148,300	0	43,399	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	144,289	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44,857	206	55,173	0	4,113	90.00
90.01	04950	WOUND CLINIC	48,455	10,646	17,566	0	12,112	90.01
91.00	09100	EMERGENCY	291,588	62,917	221,980	0	135,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	6,624	0	0	0	3,705	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	66,764	0	46,811	0	15,819	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,841,546	604,082	2,887,676	1,241,195	1,646,348	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,937,632	19,949	523,430	0	421,975	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	9,582	192.01
192.02	19202	PEDIATRICS	0	0	0	0	31,281	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0	32,845	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	42,638	0	16,676	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	31,726	0	2,969	0	6,972	194.02
194.03	07953	MH RESIDENTIAL	340,632	0	0	0	26,252	194.03
194.04	07954	UNUSED SPACE	1,948,410	0	0	0	0	194.04
194.05	07955	MOB	402,571	0	0	0	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.06	07956	FOUNDATION	7,835	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	79,223	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	615,743	0	4,453	0	0	194.09
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)	11,247,956	624,031	3,435,204	1,241,195	2,175,255	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		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
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,625,575					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	839,321				14.00
15.00	01500	PHARMACY	0	2,455	4,764,517			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	218	0	4,435,300		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	56	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	35,822	425	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	2	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	167	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	560,162	17,682	2,469	1,343,038	0	30.00
31.00	03100	INTENSIVE CARE UNIT	366,031	12,352	1,911	157,234	0	31.00
40.00	04000	SUBPROVIDER - IPF	198,387	869	248	491,355	0	40.00
41.00	04100	SUBPROVIDER - IRF	208,303	3,135	1,066	288,262	0	41.00
43.00	04300	NURSERY	23,880	689	76	72,065	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	173,172	24,953	6,753	131,028	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	92,904	23,370	710	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,106	2,896	312	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,743	9,442	44,522	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	98,281	3,417	651	0	0	55.00
60.00	06000	LABORATORY	0	109,990	590	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,752	599	0	0	65.00
66.00	06600	PHYSICAL THERAPY	117,945	1,381	881	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,807	17,964	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	7,773	926	7	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	192,592	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	262,530	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,194,028	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	128,744	15,843	10,228	871,337	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	89	1,327	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	75	0	0	0	90.00
90.01	04950	WOUND CLINIC	10,535	4,785	4,629	196,542	0	90.01
91.00	09100	EMERGENCY	402,767	13,431	3,981	884,439	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,018	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	46,928	893	116	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,590,483	714,240	4,293,068	4,435,300	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,092	98,008	356,237	0	0	192.00
192.01	19201	FP PETERSBURG	0	1,102	4,950	0	0	192.01
192.02	19202	PEDIATRICS	0	16,763	81,926	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	6,364	28,262	0	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	85	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	89	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	933	74	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	1,737	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,625,575	839,321	4,764,517	4,435,300	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH	1,227,830					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	470,409				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		1,856,458			22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			151,052		23.00
23.01	02301	PARAMED ED PRGM-LAB	0				326,290	23.01
		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
40.00	04000	SUBPROVIDER - IPF	615,389	235,205	928,229	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		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
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
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	151,052	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	326,290	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	19,813	78,193	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	615,389	255,018	1,006,422	151,052	326,290	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	215,391	850,036	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description		INTERNS & RESIDENTS				
			MENTAL HEALTH OH	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	612,441	0	0	0	0	194.09
200.00		Cross Foot Adjustments		0	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)	1,227,830	470,409	1,856,458	151,052	326,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	MENTAL HEALTH OH					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY					23.00
23.01	02301	PARAMED ED PRGM-LAB					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,265,451	0	14,265,451		30.00
31.00	03100	INTENSIVE CARE UNIT	7,863,008	0	7,863,008		31.00
40.00	04000	SUBPROVIDER - IPF	5,856,929	0	5,856,929		40.00
41.00	04100	SUBPROVIDER - IRF	4,428,427	0	4,428,427		41.00
43.00	04300	NURSERY	509,579	0	509,579		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,510,540	0	6,510,540		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	ENDOSCOPY	3,050,597	0	3,050,597		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,582,545	0	1,582,545		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,292,564	0	10,292,564		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,022,008	0	4,022,008		55.00
60.00	06000	LABORATORY	9,911,606	0	9,911,606		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	3,565,824	0	3,565,824		65.00
66.00	06600	PHYSICAL THERAPY	6,921,418	0	6,921,418		66.00
69.00	06900	ELECTROCARDIOLOGY	5,937,543	0	5,937,543		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	1,282,685	0	1,282,685		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,199,242	0	5,199,242		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,232,475	0	7,232,475		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,087,242	0	24,087,242		73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,887,387	0	3,887,387		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	922,173	0	922,173		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	365,363	0	365,363		90.00
90.01	04950	WOUND CLINIC	1,749,458	0	1,749,458		90.01
91.00	09100	EMERGENCY	9,200,041	0	9,200,041		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	252,510	0	252,510		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,729,070	0	1,729,070		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,625,685	0	140,625,685		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,683,410	0	51,683,410		192.00
192.01	19201	FP PETERSBURG	495,971	0	495,971		192.01
192.02	19202	PEDIATRICS	2,780,491	0	2,780,491		192.02
192.03	19203	WASHINGTON PRIMARY CARE	2,076,874	0	2,076,874		192.03
194.00	07950	COMMUNITY HEALTH SERVICES	154,954	0	154,954		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	727,907	0	727,907		194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.03	07953	MH RESIDENTIAL	1,650,405	0	1,650,405		194.03
194.04	07954	UNUSED SPACE	5,504,561	0	5,504,561		194.04
194.05	07955	MOB	1,176,238	0	1,176,238		194.05
194.06	07956	FOUNDATION	22,502	0	22,502		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	223,817	0	223,817		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	10,498,861	0	10,498,861		194.09
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)	217,621,676	0	217,621,676		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	124,967	110	125,077	125,077	4.00
4.01	00401	COMMUNICATIONS	0	0	0	0	343	4.01
4.02	00402	PURCHASING & RECEIVING	0	431,966	377	432,343	766	4.02
4.03	00403	REGISTRATION	0	0	0	0	1,690	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	0	0	2,879	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,172,069	1,140	1,173,209	10,264	5.00
7.00	00700	OPERATION OF PLANT	0	3,633,696	3,432	3,637,128	2,766	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	146,370	131	146,501	258	8.00
9.00	00900	HOUSEKEEPING	0	203,906	183	204,089	2,458	9.00
10.00	01000	DIETARY	0	0	0	0	545	10.00
11.00	01100	CAFETERIA	0	347,969	312	348,281	1,435	11.00
13.00	01300	NURSING ADMINISTRATION	0	238,761	214	238,975	1,670	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,502	2	2,504	455	14.00
15.00	01500	PHARMACY	0	172,025	154	172,179	3,498	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	131,110	118	131,228	3,071	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	95,671	86	95,757	620	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	111,237	100	111,337	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1,002	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	137	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	283	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,941,414	1,743	1,943,157	5,497	30.00
31.00	03100	INTENSIVE CARE UNIT	0	743,161	667	743,828	4,083	31.00
40.00	04000	SUBPROVIDER - IPF	0	362,283	325	362,608	2,366	40.00
41.00	04100	SUBPROVIDER - IRF	0	477,883	429	478,312	2,067	41.00
43.00	04300	NURSERY	0	0	0	0	311	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	525,469	472	525,941	3,940	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	340,130	305	340,435	1,206	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1,121	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	917,187	824	918,011	4,510	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	213,940	192	214,132	3,089	55.00
60.00	06000	LABORATORY	0	201,182	181	201,363	2,830	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	157,849	142	157,991	2,704	65.00
66.00	06600	PHYSICAL THERAPY	0	613,163	551	613,714	4,483	66.00
69.00	06900	ELECTROCARDIOLOGY	0	505,345	454	505,799	6,565	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	212,495	191	212,686	481	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	1,458	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	238,539	214	238,753	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	74,158	67	74,225	151	90.00
90.01	04950	WOUND CLINIC	0	80,106	72	80,178	500	90.01
91.00	09100	EMERGENCY	0	482,053	433	482,486	4,597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	10,951	10	10,961	121	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	110,375	99	110,474	542	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,019,932	13,730	15,033,662	86,762	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,203,289	2,877	3,206,166	27,629	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	326	192.01
192.02	19202	PEDIATRICS	0	0	0	0	1,739	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0	1,464	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	70,489	63	70,552	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	52,450	47	52,497	219	194.02
194.03	07953	MH RESIDENTIAL	0	563,131	506	563,637	531	194.03
194.04	07954	UNUSED SPACE	0	3,221,106	2,893	3,223,999	0	194.04
194.05	07955	MOB	0	665,529	598	666,127	0	194.05
194.06	07956	FOUNDATION	0	12,953	12	12,965	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	130,971	118	131,089	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	1,017,945	914	1,018,859	6,407	194.09
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	23,957,795	21,758	23,979,553	125,077	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	343					4.01
4.02	00402	PURCHASING & RECEIVING	3	433,112				4.02
4.03	00403	REGISTRATION	6	236	1,932			4.03
4.04	00404	PATIENT ACCOUNTS	7	211	0	3,097		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	25	7,796	0	0	1,191,294	5.00
7.00	00700	OPERATION OF PLANT	21	2,754	0	0	61,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,552	0	0	2,931	8.00
9.00	00900	HOUSEKEEPING	6	3,801	0	0	17,901	9.00
10.00	01000	DIETARY	4	28,470	0	0	6,244	10.00
11.00	01100	CAFETERIA	0	0	0	0	10,639	11.00
13.00	01300	NURSING ADMINISTRATION	3	168	0	0	13,418	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	1,791	0	0	4,210	14.00
15.00	01500	PHARMACY	5	1,130	0	0	24,937	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8	100	0	0	23,124	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	32	26	0	0	5,747	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	2,207	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4	196	0	0	9,609	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	1	0	0	811	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	77	0	0	1,748	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25	8,139	94	157	51,269	30.00
31.00	03100	INTENSIVE CARE UNIT	15	5,686	52	87	33,718	31.00
40.00	04000	SUBPROVIDER - IPF	0	400	25	42	16,060	40.00
41.00	04100	SUBPROVIDER - IRF	11	1,443	23	38	17,081	41.00
43.00	04300	NURSERY	0	317	4	6	2,157	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23	11,485	133	222	30,475	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	4	10,757	34	56	14,385	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	10	1,333	15	25	7,921	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10	4,346	234	272	50,224	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6	1,573	73	122	20,456	55.00
60.00	06000	LABORATORY	5	50,627	211	352	50,361	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	6	1,727	43	71	18,420	65.00
66.00	06600	PHYSICAL THERAPY	5	636	76	126	34,008	66.00
69.00	06900	ELECTROCARDIOLOGY	12	2,212	120	199	29,326	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	426	17	29	5,938	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	88,647	15	25	27,407	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,845	39	64	38,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	261	435	108,896	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	7,292	72	119	14,491	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	41	4	7	4,250	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	34	1	1	1,428	90.00
90.01	04950	WOUND CLINIC	2	2,202	22	36	7,906	90.01
91.00	09100	EMERGENCY	16	6,182	158	263	38,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	469	1	2	1,320	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4	411	10	17	8,494	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	283	375,539	1,737	2,773	818,027	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	53	45,111	170	283	258,541	192.00
192.01	19201	FP PETERSBURG	0	507	2	3	2,629	192.01
192.02	19202	PEDIATRICS	3	7,716	12	20	14,509	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	2,929	9	15	11,000	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	3	39	0	0	523	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	1	41	0	0	3,756	194.02
194.03	07953	MH RESIDENTIAL	0	430	2	3	7,021	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	19,467	194.04
194.05	07955	MOB	0	0	0	0	4,235	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
194.06	07956	FOUNDATION	0	0	0	0	80	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	792	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	800	0	0	50,714	194.09
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)	343	433,112	1,932	3,097	1,191,294	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	3,704,241					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,158	180,400				8.00
9.00	00900	HOUSEKEEPING	40,619	12,031	280,905			9.00
10.00	01000	DIETARY	0	3,182	7,320	45,765		10.00
11.00	01100	CAFETERIA	69,317	0	1,740	0	431,412	11.00
13.00	01300	NURSING ADMINISTRATION	47,562	0	0	0	5,945	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	498	2,345	3,087	0	4,529	14.00
15.00	01500	PHARMACY	34,268	0	2,432	0	14,414	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,118	0	2,169	0	20,822	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	19,058	3,223	7,522	0	3,338	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	22,159	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	4,309	0	2,395	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	576	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	1,361	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	386,740	57,666	69,119	20,959	37,450	30.00
31.00	03100	INTENSIVE CARE UNIT	148,042	21,835	22,376	8,989	24,471	31.00
40.00	04000	SUBPROVIDER - IPF	72,169	0	0	6,159	13,337	40.00
41.00	04100	SUBPROVIDER - IRF	95,197	10,883	12,139	9,658	13,926	41.00
43.00	04300	NURSERY	0	418	757	0	1,597	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	104,676	6,587	15,599	0	15,098	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	67,756	5,249	4,131	0	6,211	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,221	999	0	5,623	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,709	12,445	13,410	0	22,994	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	42,618	0	0	0	10,573	55.00
60.00	06000	LABORATORY	40,076	0	3,909	0	20,866	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	31,444	35	2,966	0	12,828	65.00
66.00	06600	PHYSICAL THERAPY	122,145	2,427	7,474	0	23,389	66.00
69.00	06900	ELECTROCARDIOLOGY	100,667	3,771	11,609	0	19,187	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	42,330	2,554	3,010	0	2,964	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	6,434	12,127	0	8,607	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	47,518	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,773	60	4,512	0	816	90.00
90.01	04950	WOUND CLINIC	15,958	3,078	1,436	0	2,402	90.01
91.00	09100	EMERGENCY	96,027	18,189	18,152	0	26,927	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,182	0	0	0	735	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	21,987	0	3,828	0	3,137	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,923,771	174,633	236,132	45,765	326,518	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	638,112	5,767	42,802	0	83,686	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	1,900	192.01
192.02	19202	PEDIATRICS	0	0	0	0	6,204	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0	6,514	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	14,042	0	1,364	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	10,448	0	243	0	1,383	194.02
194.03	07953	MH RESIDENTIAL	112,179	0	0	0	5,207	194.03
194.04	07954	UNUSED SPACE	641,662	0	0	0	0	194.04
194.05	07955	MOB	132,577	0	0	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.06	07956	FOUNDATION	2,580	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	26,090	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	202,780	0	364	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,704,241	180,400	280,905	45,765	431,412	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/10/2020 2:50 pm

		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
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	307,741					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,420				14.00
15.00	01500	PHARMACY	0	57	252,920			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	206,645		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	1	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,199	10	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	4	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,657	409	131	62,573	0	30.00
31.00	03100	INTENSIVE CARE UNIT	42,902	286	101	7,326	0	31.00
40.00	04000	SUBPROVIDER - IPF	23,253	20	13	22,893	0	40.00
41.00	04100	SUBPROVIDER - IRF	24,415	73	57	13,430	0	41.00
43.00	04300	NURSERY	2,799	16	4	3,358	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,297	577	358	6,105	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	10,889	541	38	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,858	67	17	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,072	218	2,363	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,519	79	35	0	0	55.00
60.00	06000	LABORATORY	0	2,545	31	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	87	32	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,824	32	47	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	111	954	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	911	21	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,455	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,075	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	222,637	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	15,090	367	543	40,596	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	2	70	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2	0	0	0	90.00
90.01	04950	WOUND CLINIC	1,235	111	246	9,157	0	90.01
91.00	09100	EMERGENCY	47,208	311	211	41,207	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	24	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	5,500	21	6	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	303,628	16,527	227,894	206,645	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,113	2,267	18,910	0	0	192.00
192.01	19201	FP PETERSBURG	0	25	263	0	0	192.01
192.02	19202	PEDIATRICS	0	388	4,349	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	147	1,500	0	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	2	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	2	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	22	4	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	40	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	307,741	19,420	252,920	206,645	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH	135,324					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	135,703				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		21,724			22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			1,525		23.00
23.01	02301	PARAMED ED PRGM-LAB	0				3,473	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
40.00	04000	SUBPROVIDER - IPF	67,823					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
51.01	05101	ENDOSCOPY	0					51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0					55.00
60.00	06000	LABORATORY	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0					63.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.01	07001	NEURODIAGNOSTICS	0					70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0					75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0					76.00
76.01	03951	INPATIENT DIALYSIS	0					76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0					90.00
90.01	04950	WOUND CLINIC	0					90.01
91.00	09100	EMERGENCY	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0					96.00
101.00	10100	HOME HEALTH AGENCY	0					101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,823	0	0	0	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
192.01	19201	FP PETERSBURG	0					192.01
192.02	19202	PEDIATRICS	0					192.02
192.03	19203	WASHINGTON PRIMARY CARE	0					192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0					194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0					194.02
194.03	07953	MH RESIDENTIAL	0					194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
194.04	07954	UNUSED SPACE	0					194.04
194.05	07955	MOB	0					194.05
194.06	07956	FOUNDATION	0					194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0					194.07
194.08	07958	INDUSTRIAL HEALTH	0					194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	67,501					194.09
200.00		Cross Foot Adjustments		135,703	21,724	1,525	3,473	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	135,324	135,703	21,724	1,525	3,473	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	MENTAL HEALTH OH					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY					23.00
23.01	02301	PARAMED ED PRGM-LAB					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,709,042	0	2,709,042		30.00
31.00	03100	INTENSIVE CARE UNIT	1,063,797	0	1,063,797		31.00
40.00	04000	SUBPROVIDER - IPF	587,168	0	587,168		40.00
41.00	04100	SUBPROVIDER - IRF	678,753	0	678,753		41.00
43.00	04300	NURSERY	11,744	0	11,744		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	741,516	0	741,516		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	ENDOSCOPY	461,692	0	461,692		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,210	0	29,210		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,215,818	0	1,215,818		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	304,275	0	304,275		55.00
60.00	06000	LABORATORY	373,176	0	373,176		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	228,354	0	228,354		65.00
66.00	06600	PHYSICAL THERAPY	822,386	0	822,386		66.00
69.00	06900	ELECTROCARDIOLOGY	680,532	0	680,532		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	271,370	0	271,370		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,549	0	120,549		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,177	0	165,177		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	332,229	0	332,229		73.00
75.00	07500	ASC (NON-DISTINCT PART)	107,196	0	107,196		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	290,645	0	290,645		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	96,004	0	96,004		90.00
90.01	04950	WOUND CLINIC	124,469	0	124,469		90.01
91.00	09100	EMERGENCY	780,718	0	780,718		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,815	0	15,815		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	154,431	0	154,431		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,366,066	0	12,366,066		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,333,610	0	4,333,610		192.00
192.01	19201	FP PETERSBURG	5,655	0	5,655		192.01
192.02	19202	PEDIATRICS	34,940	0	34,940		192.02
192.03	19203	WASHINGTON PRIMARY CARE	23,578	0	23,578		192.03
194.00	07950	COMMUNITY HEALTH SERVICES	86,525	0	86,525		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	68,590	0	68,590		194.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.03	07953	MH RESIDENTIAL	689,036	0	689,036		194.03
194.04	07954	UNUSED SPACE	3,885,128	0	3,885,128		194.04
194.05	07955	MOB	802,939	0	802,939		194.05
194.06	07956	FOUNDATION	15,625	0	15,625		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	157,971	0	157,971		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,347,465	0	1,347,465		194.09
200.00		Cross Foot Adjustments	162,425	0	162,425		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	23,979,553	0	23,979,553		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	861,939					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		871,688				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,496	4,401	101,962,470			4.00
4.01	00401	COMMUNICATIONS	0	0	279,672	2,165		4.01
4.02	00402	PURCHASING & RECEIVING	15,541	15,121	624,086	19	21,072,471	4.02
4.03	00403	REGISTRATION	0	0	1,377,517	35	11,462	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	2,346,450	43	10,287	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	42,168	45,660	8,365,059	159	379,321	5.00
7.00	00700	OPERATION OF PLANT	130,731	137,503	2,254,007	132	133,988	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,266	5,266	210,259	0	75,493	8.00
9.00	00900	HOUSEKEEPING	7,336	7,336	2,003,398	38	184,954	9.00
10.00	01000	DIETARY	0	0	444,119	26	1,385,181	10.00
11.00	01100	CAFETERIA	12,519	12,519	1,169,359	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,590	8,590	1,361,231	20	8,198	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90	90	370,879	9	87,161	14.00
15.00	01500	PHARMACY	6,189	6,189	2,850,451	31	54,987	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,717	4,717	2,503,142	52	4,880	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	3,442	3,442	505,008	203	1,248	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	4,002	4,002	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	816,358	23	9,513	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	111,300	3	42	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	230,594	0	3,742	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,847	69,847	4,480,280	157	395,990	30.00
31.00	03100	INTENSIVE CARE UNIT	26,737	26,737	3,327,354	96	276,627	31.00
40.00	04000	SUBPROVIDER - IPF	13,034	13,034	1,928,648	0	19,470	40.00
41.00	04100	SUBPROVIDER - IRF	17,193	17,193	1,684,195	70	70,218	41.00
43.00	04300	NURSERY	0	0	253,202	0	15,430	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,905	18,905	3,210,829	144	558,816	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	12,237	12,237	982,771	25	523,360	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	913,439	66	64,865	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,998	32,998	3,675,309	60	211,445	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,697	7,697	2,517,144	37	76,521	55.00
60.00	06000	LABORATORY	7,238	7,238	2,306,141	32	2,463,222	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,679	5,679	2,203,973	38	84,022	65.00
66.00	06600	PHYSICAL THERAPY	22,060	22,060	3,653,980	30	30,927	66.00
69.00	06900	ELECTROCARDIOLOGY	18,181	18,181	5,350,054	78	107,647	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	7,645	7,645	391,626	20	20,742	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,313,091	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,879,217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	1,187,873	0	354,795	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	8,582	8,582	0	3	1,986	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,668	2,668	122,981	8	1,675	90.00
90.01	04950	WOUND CLINIC	2,882	2,882	407,558	10	107,160	90.01
91.00	09100	EMERGENCY	17,343	17,343	3,746,603	102	300,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	394	394	98,826	0	22,799	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,971	3,971	441,450	23	20,007	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	540,378	550,127	70,707,125	1,792	18,271,264	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	115,246	115,246	22,546,214	326	2,194,872	192.00
192.01	19201	FP PETERSBURG	0	0	265,754	0	24,683	192.01
192.02	19202	PEDIATRICS	0	0	1,417,461	20	375,416	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	1,192,973	0	142,522	192.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
194.00	07950	COMMUNITY HEALTH SERVICES	2,536	2,536	0	20	1,906	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,887	1,887	178,524	5	2,001	194.02
194.03	07953	MH RESIDENTIAL	20,260	20,260	432,856	0	20,905	194.03
194.04	07954	UNUSED SPACE	115,887	115,887	0	0	0	194.04
194.05	07955	MOB	23,944	23,944	0	0	0	194.05
194.06	07956	FOUNDATION	466	466	0	2	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	4,712	4,712	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	36,623	36,623	5,221,563	0	38,902	194.09
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)	23,957,795	21,758	28,613,651	359,556	1,152,174	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.795233	0.024961	0.280629	166.076674	0.054677	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			125,077	343	433,112	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001227	0.158430	0.020553	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION	659,531,844					4.03
4.04	00404	PATIENT ACCOUNTS	0	659,531,844				4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-20,326,337	197,295,339		5.00
7.00	00700	OPERATION OF PLANT	0	0	0	10,197,372	669,003	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	485,478	5,266	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,964,797	7,336	9.00
10.00	01000	DIETARY	0	0	0	1,034,131	0	10.00
11.00	01100	CAFETERIA	0	0	0	1,761,968	12,519	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,222,230	8,590	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	697,270	90	14.00
15.00	01500	PHARMACY	0	0	0	4,130,089	6,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,829,710	4,717	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	0	0	951,867	3,442	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	365,470	4,002	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	1,591,475	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	134,311	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	289,440	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,394,830	31,394,830	0	8,490,983	69,847	30.00
31.00	03100	INTENSIVE CARE UNIT	17,439,101	17,439,101	0	5,584,286	26,737	31.00
40.00	04000	SUBPROVIDER - IPF	8,395,319	8,395,319	0	2,659,784	13,034	40.00
41.00	04100	SUBPROVIDER - IRF	7,646,926	7,646,926	0	2,828,904	17,193	41.00
43.00	04300	NURSERY	1,210,619	1,210,619	0	357,308	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,465,642	44,465,642	0	5,047,132	18,905	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	11,198,024	11,198,024	0	2,382,426	12,237	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,997,311	4,997,311	0	1,311,824	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,183,136	94,183,136	0	8,318,063	32,998	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	24,338,045	24,338,045	0	3,387,898	7,697	55.00
60.00	06000	LABORATORY	70,359,222	70,359,222	0	8,340,729	7,238	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	14,287,574	14,287,574	0	3,050,628	5,679	65.00
66.00	06600	PHYSICAL THERAPY	25,225,037	25,225,037	0	5,632,326	22,060	66.00
69.00	06900	ELECTROCARDIOLOGY	39,874,916	39,874,916	0	4,856,954	18,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	5,711,543	5,711,543	0	983,521	7,645	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,911,589	4,911,589	0	4,539,018	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,865,322	12,865,322	0	6,318,937	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,919,352	86,919,352	0	18,035,143	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	23,885,938	23,885,938	0	2,400,017	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,442,945	1,442,945	0	703,944	8,582	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	166,911	166,911	0	236,567	2,668	90.00
90.01	04950	WOUND CLINIC	7,295,159	7,295,159	0	1,309,298	2,882	90.01
91.00	09100	EMERGENCY	52,532,260	52,532,260	0	6,423,391	17,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	478,307	478,307	0	218,638	394	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,397,750	3,397,750	0	1,406,803	3,971	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	594,622,778	594,622,778	-20,326,337	135,480,130	347,442	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,660,417	56,660,417	0	42,814,691	115,246	192.00
192.01	19201	FP PETERSBURG	637,859	637,859	0	435,472	0	192.01
192.02	19202	PEDIATRICS	3,976,924	3,976,924	0	2,402,956	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	3,085,257	3,085,257	0	1,821,720	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	86,630	2,536	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	622,063	1,887	194.02
194.03	07953	MH RESIDENTIAL	548,609	548,609	0	1,162,724	20,260	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
194.04	07954	UNUSED SPACE	0	0	0	3,223,999	115,887	194.04
194.05	07955	MOB	0	0	0	701,405	23,944	194.05
194.06	07956	FOUNDATION	0	0	0	13,297	466	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	131,089	4,712	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	8,399,163	36,623	194.09
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)	1,793,173	4,269,750		20,326,337	11,247,956	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002719	0.006474		0.103025	16.813013	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,932	3,097		1,191,294	3,704,241	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000003	0.000005		0.006038	5.536957	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	908,893					8.00
9.00	00900	HOUSEKEEPING	60,617	69,422				9.00
10.00	01000	DIETARY	16,033	1,809	33,450			10.00
11.00	01100	CAFETERIA	0	430	0	2,146,884		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	29,585	873,525	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,817	763	0	22,536	0	14.00
15.00	01500	PHARMACY	0	601	0	71,728	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	536	0	103,617	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	16,240	1,859	0	16,612	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,065	0	11,918	11,918	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	2,864	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	6,773	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	290,528	17,082	15,319	186,365	186,365	30.00
31.00	03100	INTENSIVE CARE UNIT	110,007	5,530	6,570	121,778	121,778	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,502	66,370	66,003	40.00
41.00	04100	SUBPROVIDER - IRF	54,829	3,000	7,059	69,302	69,302	41.00
43.00	04300	NURSERY	2,106	187	0	7,945	7,945	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,189	3,855	0	75,134	57,614	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	26,447	1,021	0	30,909	30,909	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,188	247	0	27,982	27,982	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,703	3,314	0	114,429	11,559	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	52,618	32,698	55.00
60.00	06000	LABORATORY	0	966	0	103,837	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	177	733	0	63,836	0	65.00
66.00	06600	PHYSICAL THERAPY	12,229	1,847	0	116,391	39,240	66.00
69.00	06900	ELECTROCARDIOLOGY	18,998	2,869	0	95,480	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	12,869	744	0	14,750	2,586	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	32,417	2,997	0	42,833	42,833	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	300	1,115	0	4,059	0	90.00
90.01	04950	WOUND CLINIC	15,506	355	0	11,954	3,505	90.01
91.00	09100	EMERGENCY	91,638	4,486	0	134,000	134,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,657	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	946	0	15,613	15,613	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	879,838	58,357	33,450	1,624,875	861,850	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,055	10,578	0	416,471	11,675	192.00
192.01	19201	FP PETERSBURG	0	0	0	9,457	0	192.01
192.02	19202	PEDIATRICS	0	0	0	30,873	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	32,417	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	337	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	60	0	6,881	0	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
194.03	07953	MH RESIDENTIAL	0	0	0	25,910	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	90	0	0	0	194.09
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)	624,031	3,435,204	1,241,195	2,175,255	2,625,575	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.686584	49.482930	37.105979	1.013215	3.005724	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	180,400	280,905	45,765	431,412	307,741	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.198483	4.046340	1.368161	0.200948	0.352298	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,796,426					14.00
15.00	01500	PHARMACY	54,987	20,021,840				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,880	0	677			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
17.01	01701	MENTAL HEALTH OH	1,248	0	0	0	16,750,477	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	9,513	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	42	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	3,742	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	395,990	10,376	205	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	276,627	8,029	24	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	19,470	1,042	75	0	8,395,319	40.00
41.00	04100	SUBPROVIDER - IRF	70,218	4,478	44	0	0	41.00
43.00	04300	NURSERY	15,430	319	11	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	558,816	28,377	20	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	523,360	2,984	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,865	1,312	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,445	187,094	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	76,521	2,736	0	0	0	55.00
60.00	06000	LABORATORY	2,463,222	2,478	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	84,022	2,518	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	30,927	3,703	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	107,647	75,489	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	20,742	29	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,313,091	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,879,217	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,624,491	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	354,795	42,979	133	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,986	5,576	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,675	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	107,160	19,452	30	0	0	90.01
91.00	09100	EMERGENCY	300,775	16,731	135	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	22,799	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	20,007	487	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,995,219	18,040,680	677	0	8,395,319	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,194,872	1,497,009	0	0	0	192.00
192.01	19201	FP PETERSBURG	24,683	20,800	0	0	0	192.01
192.02	19202	PEDIATRICS	375,416	344,276	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	142,522	118,763	0	0	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	1,906	0	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	2,001	0	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
194.03	07953	MH RESIDENTIAL	20,905	312	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	38,902	0	0	0	8,355,158	194.09
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)	839,321	4,764,517	4,435,300	0	1,227,830	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.044653	0.237966	6,551.403250	0.000000	0.073301	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,420	252,920	206,645	0	135,324	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001033	0.012632	305.236337	0.000000	0.008079	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	736					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		736				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY			100			23.00
23.01	02301	PARAMED ED PRGM-LAB				100		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	368	368	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
51.01	05101	ENDOSCOPY	0	0	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	100	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
60.00	06000	LABORATORY	0	0	0	100		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	04950	WOUND CLINIC	0	0	0	0		90.01
91.00	09100	EMERGENCY	31	31	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	399	399	100	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	337	337	0	0		192.00
192.01	19201	FP PETERSBURG	0	0	0	0		192.01
192.02	19202	PEDIATRICS	0	0	0	0		192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0		192.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0		194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0		194.03
194.04	07954	UNUSED SPACE	0	0	0	0		194.04
194.05	07955	MOB	0	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	0		194.09
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)	470,409	1,856,458	151,052	326,290		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	639.142663	2,522.361413	1,510.520000	3,262.900000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	135,703	21,724	1,525	3,473		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	184.379076	29.516304	15.250000	34.730000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,265,451		14,265,451	0	14,265,451	30.00
31.00	03100	INTENSIVE CARE UNIT	7,863,008		7,863,008	0	7,863,008	31.00
40.00	04000	SUBPROVIDER - IPF	5,856,929		5,856,929	32,760	5,889,689	40.00
41.00	04100	SUBPROVIDER - IRF	4,428,427		4,428,427	0	4,428,427	41.00
43.00	04300	NURSERY	509,579		509,579	0	509,579	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,510,540		6,510,540	2,965	6,513,505	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	3,050,597		3,050,597	0	3,050,597	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,582,545		1,582,545	0	1,582,545	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,292,564		10,292,564	0	10,292,564	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,022,008		4,022,008	10,051	4,032,059	55.00
60.00	06000	LABORATORY	9,911,606		9,911,606	0	9,911,606	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,565,824	0	3,565,824	0	3,565,824	65.00
66.00	06600	PHYSICAL THERAPY	6,921,418	0	6,921,418	0	6,921,418	66.00
69.00	06900	ELECTROCARDIOLOGY	5,937,543		5,937,543	145,723	6,083,266	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,282,685		1,282,685	0	1,282,685	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,199,242		5,199,242	0	5,199,242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,232,475		7,232,475	0	7,232,475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,087,242		24,087,242	0	24,087,242	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,887,387		3,887,387	1,052	3,888,439	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	922,173		922,173	5,835	928,008	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	365,363		365,363	0	365,363	90.00
90.01	04950	WOUND CLINIC	1,749,458		1,749,458	0	1,749,458	90.01
91.00	09100	EMERGENCY	9,200,041		9,200,041	1,535	9,201,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,182,814		3,182,814		3,182,814	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	252,510		252,510	0	252,510	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,729,070		1,729,070		1,729,070	116.00
200.00		Subtotal (see instructions)	143,808,499	0	143,808,499	199,921	144,008,420	200.00
201.00		Less Observation Beds	3,182,814		3,182,814		3,182,814	201.00
202.00		Total (see instructions)	140,625,685	0	140,625,685	199,921	140,825,606	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/10/2020 2:50 pm

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	25,596,956		25,596,956			30.00
31.00	03100	INTENSIVE CARE UNIT	17,439,101		17,439,101			31.00
40.00	04000	SUBPROVIDER - IPF	8,395,319		8,395,319			40.00
41.00	04100	SUBPROVIDER - IRF	7,646,926		7,646,926			41.00
43.00	04300	NURSERY	1,210,619		1,210,619			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,149,227	22,316,415	44,465,642	0.146417	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,330,173	9,867,851	11,198,024	0.272423	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,830,443	166,868	4,997,311	0.316679	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,018,390	77,164,746	94,183,136	0.109282	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	658,518	23,679,527	24,338,045	0.165256	0.000000	55.00
60.00	06000	LABORATORY	22,734,323	47,624,899	70,359,222	0.140871	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	11,138,626	3,148,948	14,287,574	0.249575	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	14,932,571	10,292,466	25,225,037	0.274387	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	17,176,690	22,698,226	39,874,916	0.148904	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	104,999	5,606,544	5,711,543	0.224578	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,432,933	2,478,656	4,911,589	1.058566	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,216,261	5,649,061	12,865,322	0.562168	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,098,135	66,821,217	86,919,352	0.277122	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	114,245	23,771,693	23,885,938	0.162748	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	1,365,855	77,090	1,442,945	0.639091	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	166,911	166,911	2.188969	0.000000	90.00
90.01	04950	WOUND CLINIC	104,216	7,190,943	7,295,159	0.239811	0.000000	90.01
91.00	09100	EMERGENCY	10,880,148	41,651,978	52,532,126	0.175132	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,598,678	4,199,197	5,797,875	0.548962	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	478,307	478,307	0.527925	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,397,750	3,397,750			116.00
200.00		Subtotal (see instructions)	216,173,352	378,449,293	594,622,645			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	216,173,352	378,449,293	594,622,645			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.146484		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	ENDOSCOPY	0.272423		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165669		55.00
60.00	06000	LABORATORY	0.140871		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.249575		65.00
66.00	06600	PHYSICAL THERAPY	0.274387		66.00
69.00	06900	ELECTROCARDIOLOGY	0.152559		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	NEURODIAGNOSTICS	0.224578		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162792		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03951	INPATIENT DIALYSIS	0.643135		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2.188969		90.00
90.01	04950	WOUND CLINIC	0.239811		90.01
91.00	09100	EMERGENCY	0.175161		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962		92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925		96.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,265,451		14,265,451	0	14,265,451	30.00
31.00	03100	INTENSIVE CARE UNIT	7,863,008		7,863,008	0	7,863,008	31.00
40.00	04000	SUBPROVIDER - IPF	5,856,929		5,856,929	32,760	5,889,689	40.00
41.00	04100	SUBPROVIDER - IRF	4,428,427		4,428,427	0	4,428,427	41.00
43.00	04300	NURSERY	509,579		509,579	0	509,579	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,510,540		6,510,540	2,965	6,513,505	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	3,050,597		3,050,597	0	3,050,597	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,582,545		1,582,545	0	1,582,545	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,292,564		10,292,564	0	10,292,564	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,022,008		4,022,008	10,051	4,032,059	55.00
60.00	06000	LABORATORY	9,911,606		9,911,606	0	9,911,606	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,565,824	0	3,565,824	0	3,565,824	65.00
66.00	06600	PHYSICAL THERAPY	6,921,418	0	6,921,418	0	6,921,418	66.00
69.00	06900	ELECTROCARDIOLOGY	5,937,543		5,937,543	145,723	6,083,266	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,282,685		1,282,685	0	1,282,685	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,199,242		5,199,242	0	5,199,242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,232,475		7,232,475	0	7,232,475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,087,242		24,087,242	0	24,087,242	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,887,387		3,887,387	1,052	3,888,439	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	922,173		922,173	5,835	928,008	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	365,363		365,363	0	365,363	90.00
90.01	04950	WOUND CLINIC	1,749,458		1,749,458	0	1,749,458	90.01
91.00	09100	EMERGENCY	9,200,041		9,200,041	1,535	9,201,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,182,814		3,182,814		3,182,814	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	252,510		252,510	0	252,510	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,729,070		1,729,070		1,729,070	116.00
200.00		Subtotal (see instructions)	143,808,499	0	143,808,499	199,921	144,008,420	200.00
201.00		Less Observation Beds	3,182,814		3,182,814		3,182,814	201.00
202.00		Total (see instructions)	140,625,685	0	140,625,685	199,921	140,825,606	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/10/2020 2:50 pm

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	25,596,956		25,596,956			30.00
31.00	03100	INTENSIVE CARE UNIT	17,439,101		17,439,101			31.00
40.00	04000	SUBPROVIDER - IPF	8,395,319		8,395,319			40.00
41.00	04100	SUBPROVIDER - IRF	7,646,926		7,646,926			41.00
43.00	04300	NURSERY	1,210,619		1,210,619			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,149,227	22,316,415	44,465,642	0.146417	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,330,173	9,867,851	11,198,024	0.272423	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,830,443	166,868	4,997,311	0.316679	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,018,390	77,164,746	94,183,136	0.109282	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	658,518	23,679,527	24,338,045	0.165256	0.000000	55.00
60.00	06000	LABORATORY	22,734,323	47,624,899	70,359,222	0.140871	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	11,138,626	3,148,948	14,287,574	0.249575	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	14,932,571	10,292,466	25,225,037	0.274387	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	17,176,690	22,698,226	39,874,916	0.148904	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	104,999	5,606,544	5,711,543	0.224578	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,432,933	2,478,656	4,911,589	1.058566	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,216,261	5,649,061	12,865,322	0.562168	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,098,135	66,821,217	86,919,352	0.277122	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	114,245	23,771,693	23,885,938	0.162748	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	1,365,855	77,090	1,442,945	0.639091	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	166,911	166,911	2.188969	0.000000	90.00
90.01	04950	WOUND CLINIC	104,216	7,190,943	7,295,159	0.239811	0.000000	90.01
91.00	09100	EMERGENCY	10,880,148	41,651,978	52,532,126	0.175132	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,598,678	4,199,197	5,797,875	0.548962	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	478,307	478,307	0.527925	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,397,750	3,397,750			116.00
200.00		Subtotal (see instructions)	216,173,352	378,449,293	594,622,645			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	216,173,352	378,449,293	594,622,645			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	ENDOSCOPY	0.000000		51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	NEURODIAGNOSTICS	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03951	INPATIENT DIALYSIS	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	WOUND CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,709,042	0	2,709,042	14,701	184.28	30.00
31.00	INTENSIVE CARE UNIT	1,063,797		1,063,797	6,570	161.92	31.00
40.00	SUBPROVIDER - IPF	587,168	0	587,168	4,502	130.42	40.00
41.00	SUBPROVIDER - IRF	678,753	0	678,753	7,059	96.15	41.00
43.00	NURSERY	11,744		11,744	843	13.93	43.00
200.00	Total (lines 30 through 199)	5,050,504		5,050,504	33,675		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	6,668	1,228,779	30.00
31.00	INTENSIVE CARE UNIT	3,997	647,194	31.00
40.00	SUBPROVIDER - IPF	1,438	187,544	40.00
41.00	SUBPROVIDER - IRF	5,957	572,766	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	18,060	2,636,283	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	741,516	44,465,642	0.016676	11,157,463	186,062	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	461,692	11,198,024	0.041230	686,969	28,324	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,210	4,997,311	0.005845	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,215,818	94,183,136	0.012909	9,422,170	121,631	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	304,275	24,338,045	0.012502	431,805	5,398	55.00
60.00	06000	LABORATORY	373,176	70,359,222	0.005304	12,703,544	67,380	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	228,354	14,287,574	0.015983	5,353,118	85,559	65.00
66.00	06600	PHYSICAL THERAPY	822,386	25,225,037	0.032602	3,490,737	113,805	66.00
69.00	06900	ELECTROCARDIOLOGY	680,532	39,874,916	0.017067	8,441,725	144,075	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	271,370	5,711,543	0.047513	53,676	2,550	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,549	4,911,589	0.024544	1,393,510	34,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,177	12,865,322	0.012839	4,109,560	52,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	332,229	86,919,352	0.003822	10,185,185	38,928	73.00
75.00	07500	ASC (NON-DISTINCT PART)	107,196	23,885,938	0.004488	187	1	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	290,645	1,442,945	0.201425	945,861	190,520	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	96,004	166,911	0.575181	0	0	90.00
90.01	04950	WOUND CLINIC	124,469	7,295,159	0.017062	35,004	597	90.01
91.00	09100	EMERGENCY	780,718	52,532,126	0.014862	5,698,351	84,689	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	604,423	5,797,875	0.104249	842,818	87,863	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,815	478,307	0.033065	0	0	96.00
200.00		Total (lines 50 through 199)	7,765,554	530,935,974		74,951,683	1,244,347	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	1,163,434	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	1,163,434	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	14,701	0.00	6,668	30.00
31.00	03100	INTENSIVE CARE UNIT		0	6,570	0.00	3,997	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,163,434	4,502	258.43	1,438	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,059	0.00	5,957	41.00
43.00	04300	NURSERY		0	843	0.00	0	43.00
200.00		Total (lines 30 through 199)		1,163,434	33,675		18,060	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
40.00	04000	SUBPROVIDER - IPF	371,622	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	371,622	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
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	151,052	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	326,290	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	477,342	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 7/10/2020 2:50 pm

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	44,465,642	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	11,198,024	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,997,311	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	151,052	151,052	94,183,136	0.001604	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	24,338,045	0.000000	55.00
60.00	06000	LABORATORY	0	326,290	326,290	70,359,222	0.004637	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,287,574	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,225,037	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	39,874,916	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,711,543	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,911,589	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,865,322	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	86,919,352	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	23,885,938	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,442,945	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	166,911	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	7,295,159	0.000000	90.01
91.00	09100	EMERGENCY	98,006	98,006	98,006	52,532,126	0.001866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,797,875	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	478,307	0.000000	96.00
200.00		Total (lines 50 through 199)	98,006	575,348	575,348	530,935,974		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	11,157,463	0	9,197,955	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	686,969	0	3,628,026	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	6,474	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.001604	9,422,170	15,113	30,914,510	49,587	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	431,805	0	12,889,035	0	55.00
60.00	06000	LABORATORY	0.004637	12,703,544	58,906	7,140,952	33,113	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,353,118	0	1,481,243	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,490,737	0	203,771	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,441,725	0	11,815,611	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	53,676	0	2,147,673	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,393,510	0	1,398,241	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,109,560	0	2,804,021	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,185,185	0	30,417,960	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	187	0	8,134,087	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	945,861	0	69,300	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	2,836	0	90.00
90.01	04950	WOUND CLINIC	0.000000	35,004	0	5,157,476	0	90.01
91.00	09100	EMERGENCY	0.001866	5,698,351	10,633	10,606,196	19,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	842,818	0	3,044,118	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		74,951,683	84,652	141,059,485	102,491	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 7/10/2020 2:50 pm

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	0.146417	9,197,955	0	0	1,346,737	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	3,628,026	0	0	988,358	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	6,474	0	0	2,050	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	30,914,510	0	0	3,378,399	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165256	12,889,035	0	0	2,129,990	55.00
60.00	06000	LABORATORY	0.140871	7,140,952	0	0	1,005,953	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	1,481,243	0	0	369,681	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	203,771	0	0	55,912	66.00
69.00	06900	ELECTROCARDIOLOGY	0.148904	11,815,611	0	0	1,759,392	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	2,147,673	0	0	482,320	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	1,398,241	0	0	1,480,130	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	2,804,021	0	0	1,576,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	30,417,960	0	32,347	8,429,486	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162748	8,134,087	0	0	1,323,806	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.639091	69,300	0	0	44,289	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.188969	2,836	0	0	6,208	90.00
90.01	04950	WOUND CLINIC	0.239811	5,157,476	0	0	1,236,819	90.01
91.00	09100	EMERGENCY	0.175132	10,606,196	0	292	1,857,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	3,044,118	0	0	1,671,105	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	0	0	96.00
200.00		Subtotal (see instructions)		141,059,485	0	32,639	29,144,450	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		141,059,485	0	32,639	29,144,450	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 7/10/2020 2:50 pm

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		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
51.01	05101	ENDOSCOPY	0	0	51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,964	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	51	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	9,015	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	9,015	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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	741,516	44,465,642	0.016676	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	461,692	11,198,024	0.041230	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,210	4,997,311	0.005845	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,215,818	94,183,136	0.012909	52,238	674	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	304,275	24,338,045	0.012502	0	0	55.00
60.00	06000	LABORATORY	373,176	70,359,222	0.005304	229,072	1,215	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	228,354	14,287,574	0.015983	179,306	2,866	65.00
66.00	06600	PHYSICAL THERAPY	822,386	25,225,037	0.032602	30,020	979	66.00
69.00	06900	ELECTROCARDIOLOGY	680,532	39,874,916	0.017067	20,822	355	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	271,370	5,711,543	0.047513	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,549	4,911,589	0.024544	8,393	206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,177	12,865,322	0.012839	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	332,229	86,919,352	0.003822	280,279	1,071	73.00
75.00	07500	ASC (NON-DISTINCT PART)	107,196	23,885,938	0.004488	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	290,645	1,442,945	0.201425	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	96,004	166,911	0.575181	0	0	90.00
90.01	04950	WOUND CLINIC	124,469	7,295,159	0.017062	0	0	90.01
91.00	09100	EMERGENCY	780,718	52,532,126	0.014862	284,407	4,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,797,875	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,815	478,307	0.033065	0	0	96.00
200.00		Total (lines 50 through 199)	7,161,131	530,935,974		1,084,537	11,593	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
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	151,052	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	326,290	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	477,342	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	44,465,642	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	11,198,024	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,997,311	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	151,052	151,052	94,183,136	0.001604	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	24,338,045	0.000000	55.00
60.00	06000	LABORATORY	0	326,290	326,290	70,359,222	0.004637	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,287,574	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,225,037	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	39,874,916	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,711,543	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,911,589	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,865,322	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	86,919,352	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	23,885,938	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,442,945	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	166,911	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	7,295,159	0.000000	90.01
91.00	09100	EMERGENCY	98,006	98,006	98,006	52,532,126	0.001866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,797,875	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	478,307	0.000000	96.00
200.00		Total (lines 50 through 199)	98,006	575,348	575,348	530,935,974		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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
51.01	05101	ENDOSCOPY	0.000000	0	0	0	0	51.01
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	0.001604	52,238	84	280	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.004637	229,072	1,062	631	3	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	179,306	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	30,020	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	20,822	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	8,393	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	280,279	0	4,893	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.001866	284,407	531	4,661	9	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		1,084,537	1,677	10,465	12	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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	0.146417	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	280	0	0	31	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165256	0	0	0	0	55.00
60.00	06000	LABORATORY	0.140871	631	0	0	89	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.148904	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	4,893	0	230	1,356	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162748	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.639091	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.188969	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.239811	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.175132	4,661	0	0	816	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	0	0	96.00
200.00		Subtotal (see instructions)		10,465	0	230	2,292	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		10,465	0	230	2,292	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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
51.01	05101	ENDOSCOPY	0	0		51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	64		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	64		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	64		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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	741,516	44,465,642	0.016676	89,561	1,494	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	461,692	11,198,024	0.041230	31,823	1,312	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,210	4,997,311	0.005845	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,215,818	94,183,136	0.012909	458,996	5,925	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	304,275	24,338,045	0.012502	0	0	55.00
60.00	06000	LABORATORY	373,176	70,359,222	0.005304	1,140,022	6,047	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	228,354	14,287,574	0.015983	1,309,141	20,924	65.00
66.00	06600	PHYSICAL THERAPY	822,386	25,225,037	0.032602	8,203,636	267,455	66.00
69.00	06900	ELECTROCARDIOLOGY	680,532	39,874,916	0.017067	110,478	1,886	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	271,370	5,711,543	0.047513	11,067	526	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,549	4,911,589	0.024544	153,178	3,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,177	12,865,322	0.012839	3,879	50	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	332,229	86,919,352	0.003822	1,527,827	5,839	73.00
75.00	07500	ASC (NON-DISTINCT PART)	107,196	23,885,938	0.004488	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	290,645	1,442,945	0.201425	97,020	19,542	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	96,004	166,911	0.575181	0	0	90.00
90.01	04950	WOUND CLINIC	124,469	7,295,159	0.017062	0	0	90.01
91.00	09100	EMERGENCY	780,718	52,532,126	0.014862	97,753	1,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,797,875	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,815	478,307	0.033065	0	0	96.00
200.00		Total (lines 50 through 199)	7,161,131	530,935,974		13,234,381	336,213	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
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	151,052	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	326,290	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	477,342	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	44,465,642	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	11,198,024	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,997,311	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	151,052	151,052	94,183,136	0.001604	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	24,338,045	0.000000	55.00
60.00	06000	LABORATORY	0	326,290	326,290	70,359,222	0.004637	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,287,574	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,225,037	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	39,874,916	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,711,543	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,911,589	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,865,322	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	86,919,352	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	23,885,938	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,442,945	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	166,911	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	7,295,159	0.000000	90.01
91.00	09100	EMERGENCY	98,006	98,006	98,006	52,532,126	0.001866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,797,875	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	478,307	0.000000	96.00
200.00		Total (lines 50 through 199)	98,006	575,348	575,348	530,935,974		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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	89,561	0	5	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	31,823	0	0	0	51.01
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	0.001604	458,996	736	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	33	0	55.00
60.00	06000	LABORATORY	0.004637	1,140,022	5,286	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,309,141	0	11	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,203,636	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	110,478	0	34	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	11,067	0	5	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	153,178	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,879	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,527,827	0	37	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	97,020	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.000000	0	0	10	0	90.01
91.00	09100	EMERGENCY	0.001866	97,753	182	876	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		13,234,381	6,204	1,011	2	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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	0.146417	5	0	0	1	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165256	33	0	0	5	55.00
60.00	06000	LABORATORY	0.140871	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	11	0	0	3	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.148904	34	0	0	5	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	5	0	0	1	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	37	0	721	10	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162748	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.639091	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.188969	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.239811	10	0	0	2	90.01
91.00	09100	EMERGENCY	0.175132	876	0	0	153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	0	0	96.00
200.00		Subtotal (see instructions)		1,011	0	721	180	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,011	0	721	180	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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
51.01	05101	ENDOSCOPY	0	0		51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	200		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	200		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	200		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,701	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,701	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,421	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	6,668	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)	14,265,451	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)	14,265,451	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,265,451	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)	970.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,470,427	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)	6,470,427	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,863,008	6,570	1,196.80	3,997	4,783,610	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)	16,991,508	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	28,245,545	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)	1,875,973	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,328,999	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,204,972	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	25,040,573	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)	3,280	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	970.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,182,814	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,709,042	14,265,451	0.189902	3,182,814	604,423	90.00
91.00	Nursing School cost	0	14,265,451	0.000000	3,182,814	0	91.00
92.00	Allied health cost	0	14,265,451	0.000000	3,182,814	0	92.00
93.00	All other Medical Education	0	14,265,451	0.000000	3,182,814	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/10/2020 2:50 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,502	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,502	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,502	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,438	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)	5,889,689	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)	5,889,689	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,889,689	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)	1,308.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,881,249	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)	1,881,249	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1

Component CCN: 15-S042 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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	0	0	0.00	0	0	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)	230,516	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,111,765	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)	559,166	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	13,270	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	572,436	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,539,329	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1

Component CCN: 15-S042 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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	587,168	5,889,689	0.099694	0	0	90.00
91.00	Nursing School cost	0	5,889,689	0.000000	0	0	91.00
92.00	Allied health cost	0	5,889,689	0.000000	0	0	92.00
93.00	All other Medical Education	1,163,434	5,889,689	0.197537	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/10/2020 2:50 pm
	Title XVIII	Subprovider - IRF	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)	7,059	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,059	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,059	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	5,957	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)	4,428,427	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)	4,428,427	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,428,427	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)	627.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,737,064	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,737,064	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1

Component CCN: 15-T042 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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	0	0	0.00	0	0	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)	3,496,827	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,233,891	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)	572,766	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	342,417	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	915,183	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,318,708	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1

Component CCN: 15-T042 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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	678,753	4,428,427	0.153272	0	0	90.00
91.00	Nursing School cost	0	4,428,427	0.000000	0	0	91.00
92.00	Allied health cost	0	4,428,427	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,428,427	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,701	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,701	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,421	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	395	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)	843	15.00
16.00	Nursery days (title V or XIX only)	60	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)	14,265,451	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)	14,265,451	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,265,451	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)	970.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	383,296	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)	383,296	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	509,579	843	604.48	60	36,269	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,863,008	6,570	1,196.80	0	0	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)	533,344	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	952,909	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,280	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	970.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,182,814	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,709,042	14,265,451	0.189902	3,182,814	604,423	90.00
91.00	Nursing School cost	0	14,265,451	0.000000	3,182,814	0	91.00
92.00	Allied health cost	0	14,265,451	0.000000	3,182,814	0	92.00
93.00	All other Medical Education	0	14,265,451	0.000000	3,182,814	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/10/2020 2:50 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,502	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,502	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,502	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	288	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)	843	15.00
16.00	Nursery days (title V or XIX only)	60	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)	5,856,929	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)	5,856,929	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,856,929	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)	1,300.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	374,676	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)	374,676	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	21,886	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	396,562	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1

Component CCN: 15-S042 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	587,168	5,856,929	0.100252	0	0	90.00
91.00	Nursing School cost	0	5,856,929	0.000000	0	0	91.00
92.00	Allied health cost	0	5,856,929	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,856,929	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/10/2020 2:50 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,059	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,059	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,059	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	42	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)	843	15.00
16.00	Nursery days (title V or XIX only)	60	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)	4,428,427	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)	4,428,427	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,428,427	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)	627.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	26,348	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)	26,348	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	17,528	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	43,876	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1

Component CCN: 15-T042 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	678,753	4,428,427	0.153272	0	0	90.00
91.00	Nursing School cost	0	4,428,427	0.000000	0	0	91.00
92.00	Allied health cost	0	4,428,427	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,428,427	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		12,717,803		30.00
31.00	03100	INTENSIVE CARE UNIT		9,954,663		31.00
40.00	04000	SUBPROVIDER - IPF		1,275		40.00
41.00	04100	SUBPROVIDER - IRF		57,213		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.146484	11,157,463	1,634,390	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	686,969	187,146	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	9,422,170	1,029,674	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165669	431,805	71,537	55.00
60.00	06000	LABORATORY	0.140871	12,703,544	1,789,561	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	5,353,118	1,336,004	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	3,490,737	957,813	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152559	8,441,725	1,287,861	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	53,676	12,054	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	1,393,510	1,475,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	4,109,560	2,310,263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	10,185,185	2,822,539	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162792	187	30	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.643135	945,861	608,316	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.188969	0	0	90.00
90.01	04950	WOUND CLINIC	0.239811	35,004	8,394	90.01
91.00	09100	EMERGENCY	0.175161	5,698,351	998,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	842,818	462,675	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		74,951,683	16,991,508	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)		74,951,683		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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
40.00	04000	SUBPROVIDER - IPF		2,343,812		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.146484	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	52,238	5,709	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165669	0	0	55.00
60.00	06000	LABORATORY	0.140871	229,072	32,270	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	179,306	44,750	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	30,020	8,237	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152559	20,822	3,177	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	8,393	8,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	280,279	77,671	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162792	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.643135	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.188969	0	0	90.00
90.01	04950	WOUND CLINIC	0.239811	0	0	90.01
91.00	09100	EMERGENCY	0.175161	284,407	49,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,084,537	230,516	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)		1,084,537		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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		335,067		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		6,294,034		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.146484	89,561	13,119	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	31,823	8,669	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	458,996	50,160	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165669	0	0	55.00
60.00	06000	LABORATORY	0.140871	1,140,022	160,596	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	1,309,141	326,729	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	8,203,636	2,250,971	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152559	110,478	16,854	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	11,067	2,485	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	153,178	162,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	3,879	2,181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	1,527,827	423,394	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162792	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.643135	97,020	62,397	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.188969	0	0	90.00
90.01	04950	WOUND CLINIC	0.239811	0	0	90.01
91.00	09100	EMERGENCY	0.175161	97,753	17,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,234,381	3,496,827	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		13,234,381		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		325,010		30.00
31.00	03100	INTENSIVE CARE UNIT		305,764		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		99,964		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.146417	310,014	45,391	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	16,760	4,566	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	368,034	116,549	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	293,335	32,056	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165256	6,110	1,010	55.00
60.00	06000	LABORATORY	0.140871	446,386	62,883	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	207,365	51,753	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	87,803	24,092	66.00
69.00	06900	ELECTROCARDIOLOGY	0.148904	253,717	37,779	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	1,842	414	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	371,769	103,025	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162748	961	156	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.639091	13,783	8,809	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.188969	0	0	90.00
90.01	04950	WOUND CLINIC	0.239811	882	212	90.01
91.00	09100	EMERGENCY	0.175132	246,482	43,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	2,700	1,482	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,627,943	533,344	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,627,943		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		457,891		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.146417	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	166	45	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	13,438	1,469	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165256	0	0	55.00
60.00	06000	LABORATORY	0.140871	30,259	4,263	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	8,466	2,113	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	7,411	2,033	66.00
69.00	06900	ELECTROCARDIOLOGY	0.148904	2,235	333	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	654	147	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	1,551	1,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	34,131	9,458	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162748	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.639091	600	383	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.188969	0	0	90.00
90.01	04950	WOUND CLINIC	0.239811	0	0	90.01
91.00	09100	EMERGENCY	0.175132	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		98,911	21,886	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)		98,911		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		52,755		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.146417	163	24	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.272423	423	115	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.316679	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109282	4,123	451	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165256	0	0	55.00
60.00	06000	LABORATORY	0.140871	6,086	857	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.249575	1,871	467	65.00
66.00	06600	PHYSICAL THERAPY	0.274387	43,309	11,883	66.00
69.00	06900	ELECTROCARDIOLOGY	0.148904	786	117	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.224578	99	22	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566	1,568	1,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562168	61	34	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277122	6,264	1,736	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.162748	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.639091	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.188969	0	0	90.00
90.01	04950	WOUND CLINIC	0.239811	674	162	90.01
91.00	09100	EMERGENCY	0.175132	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.548962	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.527925	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		65,427	17,528	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)		65,427		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		MDH	Non MDH	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1.00	DRG Amounts Other than Outlier Payments	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6,985,700	10,016,125	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,040,688	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	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	0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount	0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	29,567	52,487	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	29,704	0	2.04
3.00	Managed Care Simulated Payments	2,273,859	1,221,352	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	88.57		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	0.76		16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	0.76		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.008581		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.008864		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.008581		21.00
22.00	IME payment adjustment (see instructions)	56,271	46,865	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	10,639	5,715	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	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	56,271	46,865	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	10,639	5,715	29.01
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.88		30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.01		31.00
32.00	Sum of lines 30 and 31	19.89		32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.69	5.69	33.00
34.00	Disproportionate share adjustment (see instructions)	171,076	142,480	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		MDH Prior to 10/1	Non MDH	On/After 10/1	
		1.00	1.01	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	0		8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000000000		0.000245589	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,229,118		2,050,815	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,667,258		515,505	35.03
35.04	Pro rata share of the hospital uncompensated care payment amount (MDH)	732,860	934,398	515,505	35.04
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,182,763			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

		MDH	Non MDH	
		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)	13,561,371	11,192,355	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	14,899,248	0	48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	25,773,488	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,799,889	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	6,748	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)	84,652	58.00
59.00	Total (sum of amounts on lines 49 through 58)	27,664,777	59.00
60.00	Primary payer payments	5,648	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	27,659,129	61.00
62.00	Deductibles billed to program beneficiaries	2,608,780	62.00
63.00	Coinsurance billed to program beneficiaries	43,295	63.00
64.00	Allowable bad debts (see instructions)	330,957	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	215,122	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	173,169	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	25,222,176	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)	939	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-4,495	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	17,337	70.93
70.94	HRR adjustment amount (see instructions)	-80,181	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A | Date/Time Prepared: 7/10/2020 2:50 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		275,070	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		24,880,706	71.00
71.01	Sequestration adjustment (see instructions)		497,614	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		24,340,863	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		42,229	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		586,872	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)	567,967	435,441	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0006210634	1.0013449050	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	353	586	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9973	0.9932	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-1,534	-2,961	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: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/10/2020 2:50 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Before 10/01 MDH	Before 10/01 Non MDH	Period On/After 10/01	
		0	1.00	2.00	3.00	3.01	4.00	
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	17,001,825	0	17,001,825	0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,040,688	0			5,040,688	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	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	82,054	0	82,054	0		2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	29,704	0			29,704	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3,495,211	0	2,439,455	0	1,055,756	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.008581	0.008581	0.008581	0.008581	0.008581	5.00
6.00	IME payment adjustment (see instructions)	22.00	103,136	0	79,551	0	23,585	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	16,354	0	11,414	0	4,940	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	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	103,136	0	79,551	0	23,585	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	16,354	0	11,414	0	4,940	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0569	0.0569	0.0569	0.0569	0.0569	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	313,556	0	241,852	0	71,704	11.00
11.01	Uncompensated care payments	36.00	2,182,763	0	1,667,258	0	515,505	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	24,753,726	0	19,072,540	0	5,681,186	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	14,899,248	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	25,773,488	0	20,087,362	0	5,686,126	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,799,889	0	-407,996	0	2,207,885	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/10/2020 2:50 pm

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					Before 10/01			
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	MDH	Non MDH	Period On/After 10/01	
		0	1.00	2.00	3.00	3.01	4.00	
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	19,679,366	0	7,894,011	19.00
		W/S L, line	(Amounts from L)		MDH	Non MDH		
		0	1.00	2.00	3.00	3.01	4.00	
20.00	Capital DRG other than outlier	1.00	1,765,397	0	-397,780	0	2,163,177	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	26,901	0	-8,506	0	35,407	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	0.0043	0.0043	0.0043	0.0043	0.0043	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7,591	0	-1,710	0	9,301	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	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	1,799,889	0	-407,996	0	2,207,885	26.00
		W/S E, Part A line	(Amounts to E, Part A)		MDH	Non MDH		
		0	1.00	2.00	3.00	3.01	4.00	
27.00	Low volume adjustment factor				0.000000	0.000000	0.000000	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				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/10/2020 2:50 pm

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		Total (Col 2 through 4)				
		5.00				
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	17,001,825				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	5,040,688				1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	0				1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	0				1.04
2.00	Outlier payments for discharges (see instructions)					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	0				2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	82,054				2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	29,704				2.03
3.00	Operating outlier reconciliation	0				3.00
4.00	Managed care simulated payments	3,495,211				4.00
	Indirect Medical Education Adjustment					
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)					5.00
6.00	IME payment adjustment (see instructions)	103,136				6.00
6.01	IME payment adjustment for managed care (see instructions)	16,354				6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
7.00	IME payment adjustment factor (see instructions)					7.00
8.00	IME adjustment (see instructions)	0				8.00
8.01	IME payment adjustment add on for managed care (see instructions)	0				8.01
9.00	Total IME payment (sum of lines 6 and 8)	103,136				9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	16,354				9.01
	Disproportionate Share Adjustment					
10.00	Allowable disproportionate share percentage (see instructions)					10.00
11.00	Disproportionate share adjustment (see instructions)	313,556				11.00
11.01	Uncompensated care payments	2,182,763				11.01
	Additional payment for high percentage of ESRD beneficiary discharges					
12.00	Total ESRD additional payment (see instructions)	0				12.00
13.00	Subtotal (see instructions)	24,753,726				13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	0				14.00
15.00	Total payment for inpatient operating costs (see instructions)	25,773,488				15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	1,799,889				16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/10/2020 2:50 pm

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		Total (Col 2 through 4)				
		5.00				
17.00	Special add-on payments for new technologies	0				17.00
17.01	Net organ aquisition cost					17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	0				17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0				18.00
19.00	SUBTOTAL	27,573,377				19.00
		5.00				
20.00	Capital DRG other than outlier	1,765,397				20.00
20.01	Model 4 BPCI Capital DRG other than outlier	0				20.01
21.00	Capital DRG outlier payments	26,901				21.00
21.01	Model 4 BPCI Capital DRG outlier payments	0				21.01
22.00	Indirect medical education percentage (see instructions)					22.00
23.00	Indirect medical education adjustment (see instructions)	7,591				23.00
24.00	Allowable disproportionate share percentage (see instructions)					24.00
25.00	Disproportionate share adjustment (see instructions)	0				25.00
26.00	Total prospective capital payments (see instructions)	1,799,889				26.00
		5.00				
27.00	Low volume adjustment factor					27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	0				28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	0				29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/10/2020 2:50 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Before 10/01		Period on after 10/01	
				MDH	Non MDH		
		0	1.00	2.00	2.01	3.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	17,001,825	17,001,825	0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,040,688			5,040,688	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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	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	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	82,054	82,054	0		2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	29,704			29,704	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3,495,211	2,439,455	0	1,055,756	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.008581	0.008581	0.008581	0.008581	5.00
6.00	IME payment adjustment (see instructions)	22.00	103,136	79,551	0	23,585	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	16,354	11,414	0	4,940	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	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	103,136	79,551	0	23,585	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	16,354	11,414	0	4,940	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0569	0.0569	0.0569	0.0569	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	313,556	241,852	0	71,704	11.00
11.01	Uncompensated care payments	36.00	2,182,763	732,860	934,398	515,505	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	12.00
13.00	Subtotal (see instructions)	47.00	24,753,726	18,138,142	934,398	5,681,186	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	14,899,248	8,726,813	0	6,172,435	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	25,773,488	18,784,527	934,398	6,054,563	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,799,889	-407,996	0	2,207,885	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			18,376,531	934,398	8,262,448	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/10/2020 2:50 pm

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		Wkst. L, line	(Amt. from Wkst. L)	MDH	Non MDH		
		0	1.00	2.00	2.01	3.00	
20.00	Capital DRG other than outlier	1.00	1,765,397	-397,780	0	2,163,177	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	26,901	-8,506	0	35,407	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0043	0.0043	0.0043	0.0043	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7,591	-1,710	0	9,301	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	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,799,889	-407,996	0	2,207,885	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)	MDH	Non MDH		
		0	1.00	2.00	2.01	3.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0	0		28.00
29.00	Low volume adjustment on or after October 1	70.97	0			0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	17,337	10,558	0	6,779	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	939	353	0	586	30.01
31.00	HRR adjustment (see instructions)	70.94	-80,181	-45,904	0	-34,277	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-4,495	-1,534	0	-2,961	31.01
				MDH	Non MDH		
		0	1.00	2.00	2.01	3.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		183,400	9,344	82,326	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/10/2020 2:50 pm

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		Total (cols. 2 and 3)		
		4.00		
1.00	DRG amounts other than outlier payments			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	17,001,825		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	5,040,688		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	0		1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	0		1.04
2.00	Outlier payments for discharges (see instructions)			2.00
2.01	Outlier payments for discharges for Model 4 BPCI	0		2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	82,054		2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	29,704		2.03
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	3,495,211		4.00
	Indirect Medical Education Adjustment			
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	103,136		6.00
6.01	IME payment adjustment for managed care (see instructions)	16,354		6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
7.00	IME payment adjustment factor (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
8.01	IME payment adjustment add on for managed care (see instructions)	0		8.01
9.00	Total IME payment (sum of lines 6 and 8)	103,136		9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	16,354		9.01
	Disproportionate Share Adjustment			
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	313,556		11.00
11.01	Uncompensated care payments	2,182,763		11.01
	Additional payment for high percentage of ESRD beneficiary discharges			
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	24,753,726		13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	14,899,248		14.00
15.00	Total payment for inpatient operating costs (see instructions)	25,773,488		15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	1,799,889		16.00
17.00	Special add-on payments for new technologies	0		17.00
17.01	Net organ acquisition cost			17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	0		17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	27,573,377		19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/10/2020 2:50 pm

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		4.00		
20.00	Capital DRG other than outlier	1,765,397		20.00
20.01	Model 4 BPCI Capital DRG other than outlier	0		20.01
21.00	Capital DRG outlier payments	26,901		21.00
21.01	Model 4 BPCI Capital DRG outlier payments	0		21.01
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (see instructions)	7,591		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (see instructions)	0		25.00
26.00	Total prospective capital payments (see instructions)	1,799,889		26.00
		4.00		
27.00				27.00
28.00	Low volume adjustment prior to October 1	0		28.00
29.00	Low volume adjustment on or after October 1	0		29.00
30.00	HVBP payment adjustment (see instructions)	17,337		30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	939		30.01
31.00	HRR adjustment (see instructions)	-80,181		31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	-4,495		31.01
		(Amt. to Wkst. E, Pt. A)		
		4.00		
32.00	HAC Reduction Program adjustment (see instructions)	275,070		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/10/2020 2:50 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,015	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	29,041,959	2.00
3.00	OPPS payments	27,422,318	3.00
4.00	Outlier payment (see instructions)	80,035	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	102,491	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,015	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	32,639	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)	32,639	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)	32,639	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	23,624	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,015	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)	27,604,844	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)	5,342,462	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)	22,271,397	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)	22,271,397	30.00
31.00	Primary payer payments	11,297	31.00
32.00	Subtotal (line 30 minus line 31)	22,260,100	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)	804,850	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	523,153	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	542,150	36.00
37.00	Subtotal (see instructions)	22,783,253	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-96	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)	22,783,349	40.00
40.01	Sequestration adjustment (see instructions)	455,667	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	22,113,348	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	214,334	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/10/2020 2:50 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	64	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,280	2.00
3.00	OPPS payments	2,521	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	12	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	64	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	230	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)	230	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)	230	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	166	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)	64	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)	2,533	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)	437	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)	2,160	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)	2,160	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,160	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)	425	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	276	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	425	36.00
37.00	Subtotal (see instructions)	2,436	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,436	40.00
40.01	Sequestration adjustment (see instructions)	49	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,109	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	278	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/10/2020 2:50 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	200	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	178	2.00
3.00	OPPS payments	508	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	2	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	200	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	721	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)	721	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)	721	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	521	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)	200	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)	510	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)	21	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)	689	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)	689	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	689	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)	689	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	689	40.00
40.01	Sequestration adjustment (see instructions)	14	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	690	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-15	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		24,143,191		21,708,859	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2019	197,672	12/31/2019	368,589	3.01
3.02			0	05/08/2019	35,900	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		197,672		404,489	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)		24,340,863		22,113,348	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		42,229		214,334	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		24,383,092		22,327,682	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: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IPF | 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		984,500		2,109	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)		984,500		2,109	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		426,478		278	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,410,978		2,387	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: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Subprovider - IRF | 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		8,227,999		690	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)		8,227,999		690	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		25,293		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		15	6.02
7.00	Total Medicare program liability (see instructions)		8,253,292		675	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: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 7/10/2020 2:50 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 7/10/2020 2:50 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,231,444	1.00
2.00	Net IPF PPS Outlier Payments	20,281	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	1.01	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	1.01	8.00
9.00	Average Daily Census (see instructions)	12.334247	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.041366	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	50,940	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,302,665	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,302,665	16.00
17.00	Primary payer payments	3,636	17.00
18.00	Subtotal (line 16 less line 17).	1,299,029	18.00
19.00	Deductibles	167,724	19.00
20.00	Subtotal (line 18 minus line 19)	1,131,305	20.00
21.00	Coinsurance	75,702	21.00
22.00	Subtotal (line 20 minus line 21)	1,055,603	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,725	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	10,871	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,705	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,066,474	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	373,299	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,439,773	31.00
31.01	Sequestration adjustment (see instructions)	28,795	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	984,500	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	426,478	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	20,281	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part III Date/Time Prepared: 7/10/2020 2:50 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8,188,370	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0351	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	153,941	3.00
4.00	Outlier Payments	176,814	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	19.339726	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	8,519,125	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	8,519,125	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	8,519,125	19.00
20.00	Deductibles	106,344	20.00
21.00	Subtotal (line 19 minus line 20)	8,412,781	21.00
22.00	Coinsurance	7,843	22.00
23.00	Subtotal (line 21 minus line 22)	8,404,938	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,285	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	10,585	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,910	26.00
27.00	Subtotal (sum of lines 23 and 25)	8,415,523	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	6,204	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	8,421,727	32.00
32.01	Sequestration adjustment (see instructions)	168,435	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	8,227,999	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	25,293	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	176,814	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	952,909		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	952,909	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	952,909	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	730,738		8.00
9.00	Ancillary service charges	2,627,943	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	3,358,681	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	3,358,681	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,405,772	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	952,909	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	952,909	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	952,909	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	952,909	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	952,909	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	952,909	0	40.00
41.00	Interim payments	1,558,430	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-605,521	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Subprovider - IPF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	396,562		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	396,562	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	396,562	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	457,891		8.00
9.00	Ancillary service charges	98,911	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	556,802	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	556,802	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	160,240	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	396,562	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	396,562	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	396,562	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	396,562	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	396,562	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	396,562	0	40.00
41.00	Interim payments	213,564	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	182,998	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII | Date/Time Prepared: 7/10/2020 2:50 pm

Title XIX | Subprovider - IRF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	43,876		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	43,876	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	43,876	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	52,755		8.00
9.00	Ancillary service charges	65,427	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	118,182	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	118,182	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	74,306	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	43,876	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	43,876	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	43,876	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	43,876	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	43,876	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	43,876	0	40.00
41.00	Interim payments	74,451	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-30,575	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 7/10/2020 2:50 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	26,806,742	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	80,326,635	0	0	0	4.00
5.00	Other receivable	6,700,168	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-49,925,885	0	0	0	6.00
7.00	Inventory	1,892,688	0	0	0	7.00
8.00	Prepaid expenses	4,605,388	0	0	0	8.00
9.00	Other current assets	399,010	0	0	0	9.00
10.00	Due from other funds	1,011,491	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	71,816,237	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,581,448	0	0	0	12.00
13.00	Land improvements	4,198,345	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	163,818,192	0	0	0	15.00
16.00	Accumulated depreciation	-72,255,913	0	0	0	16.00
17.00	Leasehold improvements	850,562	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	218,400,469	0	0	0	23.00
24.00	Accumulated depreciation	-145,531,622	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	176,061,481	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	59,025,081	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	632,816	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	59,657,897	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	307,535,615	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,312,575	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,437,202	0	0	0	38.00
39.00	Payroll taxes payable	11,127,062	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,786,498	0	0	0	40.00
41.00	Deferred income	68,276	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,480,101	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,211,714	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	109,060,586	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	439,115	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	109,499,701	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	131,711,415	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	175,824,200				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)	175,824,200	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	307,535,615	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 7/10/2020 2:50 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		165,847,567		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,976,632				2.00
3.00	Total (sum of line 1 and line 2)		175,824,199		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)		175,824,199		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		175,824,199		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/10/2020 2:50 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	26,807,575		26,807,575	1.00
2.00	SUBPROVIDER - IPF	8,395,319		8,395,319	2.00
3.00	SUBPROVIDER - IRF	7,646,926		7,646,926	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	42,849,820		42,849,820	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	17,439,101		17,439,101	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)	17,439,101		17,439,101	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	60,288,921		60,288,921	17.00
18.00	Ancillary services	143,301,390	321,364,206	464,665,596	18.00
19.00	Outpatient services	12,583,041	53,209,162	65,792,203	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	3,397,750	3,397,750	26.00
27.00	DME	0	478,307	478,307	27.00
27.01	PHYSICIAN OFFICE	7,666,020	65,598,204	73,264,224	27.01
27.02	PROFESSIONAL FEES	0	10,738,321	10,738,321	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	223,839,372	454,785,950	678,625,322	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		244,016,427		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)		244,016,427		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 7/10/2020 2:50 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	678,625,322	1.00
2.00	Less contractual allowances and discounts on patients' accounts	444,385,444	2.00
3.00	Net patient revenues (line 1 minus line 2)	234,239,878	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	244,016,427	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,776,549	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	4,151,848	23.00
24.00	OTHER REVENUE	4,334,671	24.00
24.01	INVESTMENT INCOME	6,246,114	24.01
24.02	INTEREST EXPENSE	0	24.02
24.03	OTHER NONOPERATING	1,747,525	24.03
24.04	INTERCOMPANY TRANSFERS	2,605,371	24.04
24.05	UPL	25,492	24.05
24.06	DIETARY REVENUE	642,160	24.06
24.07	OTHER (SPECIFY)	0	24.07
25.00	Total other income (sum of lines 6-24)	19,753,181	25.00
26.00	Total (line 5 plus line 25)	9,976,632	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)	9,976,632	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O | Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	94,607	709,519	804,126	-102,776	701,350	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,020	3,020	0	3,020	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	3,404	3,404	0	3,404	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	487	487	0	487	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	11,623	2,706	14,329	0	14,329	26.00
27.00	NURSE PRACTITIONER**	385	90	475	0	475	27.00
28.00	REGISTERED NURSE**	231,867	53,983	285,850	0	285,850	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	45,443	10,580	56,023	0	56,023	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	56,932	13,255	70,187	0	70,187	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	594	139	733	0	733	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	438	438	0	438	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	441,451	797,621	1,239,072	-102,776	1,136,296	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O | Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	701,350		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,020		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	3,404		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	487		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	14,329		26.00
27.00	NURSE PRACTITIONER**	0	475		27.00
28.00	REGISTERED NURSE**	0	285,850		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	56,023		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	70,187		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	733		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	438		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	1,136,296		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-2 | Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	10,726	2,497	13,223	0	13,223	26.00
27.00	NURSE PRACTITIONER	355	83	438	0	438	27.00
28.00	REGISTERED NURSE	213,958	49,813	263,771	0	263,771	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	41,933	9,763	51,696	0	51,696	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	52,535	12,231	64,766	0	64,766	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	548	128	676	0	676	46.00
100.00	TOTAL *	320,055	74,515	394,570	0	394,570	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	13,223		26.00
27.00	NURSE PRACTITIONER	0	438		27.00
28.00	REGISTERED NURSE	0	263,771		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	51,696		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	64,766		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	676		46.00
100.00	TOTAL *	0	394,570		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-3 | Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	89	21	110	0	110	26.00
27.00	NURSE PRACTITIONER	3	1	4	0	4	27.00
28.00	REGISTERED NURSE	1,781	415	2,196	0	2,196	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	349	81	430	0	430	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	437	102	539	0	539	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	5	1	6	0	6	46.00
100.00	TOTAL *	2,664	621	3,285	0	3,285	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	110		26.00
27.00	NURSE PRACTITIONER	0	4		27.00
28.00	REGISTERED NURSE	0	2,196		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	430		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	539		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	6		46.00
100.00	TOTAL *	0	3,285		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-4 | Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	808	188	996	0	996	26.00
27.00	NURSE PRACTITIONER	27	6	33	0	33	27.00
28.00	REGISTERED NURSE	16,128	3,755	19,883	0	19,883	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	3,161	736	3,897	0	3,897	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	3,960	922	4,882	0	4,882	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	41	10	51	0	51	46.00
100.00	TOTAL *	24,125	5,617	29,742	0	29,742	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	996		26.00
27.00	NURSE PRACTITIONER	0	33		27.00
28.00	REGISTERED NURSE	0	19,883		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	3,897		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	4,882		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	51		46.00
100.00	TOTAL *	0	29,742		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0042 Hospice CCN: 15-1526

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

Worksheet O-5

Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	110,375	110,375	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	99	99	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	160,033	160,033	3.00
4.00	ADMINISTRATIVE & GENERAL	701,350	160,755	862,105	4.00
5.00	PLANT OPERATION & MAINTENANCE	3,020	66,764	69,784	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	46,811	46,811	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	46,928	46,928	9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,404	893	4,297	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	487	116	603	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	394,570		394,570	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,285		3,285	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	29,742		29,742	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	438		438	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,136,296	592,774	1,729,070	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet O-6 Part I
Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	110,375	110,375				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	99		99			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	160,033	0	0	160,033		3.00
4.00	ADMINISTRATIVE & GENERAL	862,105	0	0	0	862,105	4.00
5.00	PLANT OPERATION & MAINTENANCE	69,784	0	0	0	69,784	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	46,811	0	0	0	46,811	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	46,928	0	0	0	46,928	9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,297	0	0	0	4,297	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	603	0	0	0	603	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	394,570			147,673	542,243	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,285	10,941	10	1,229	15,465	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	29,742	99,434	89	11,131	140,396	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	438	0	0	0	438	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,729,070	110,375	99	160,033	1,729,070	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet O-6 Part I
Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	862,105					4.00
5.00	PLANT OPERATION & MAINTENANCE	69,393	139,177				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	46,549	0		93,360		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	46,665	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,273	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	600	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	539,202					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	15,378	13,796	0	9,254	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	139,609	125,381	0	84,106	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	436	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	862,105	139,177	0	93,360	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet O-6 Part I
Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	93,593					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	8,570				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	86,364	7,908	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	719	66	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	6,510	596	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	93,593	8,570	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet O-6 Part I
Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	1,203					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,111	0	0		1,176,828	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	9	0	0	0	54,687	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	83	0	0	0	496,681	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		874	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,203	0	0	0	1,729,070	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet O-6
Part II
Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	686					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		686				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	160,036			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-862,105	866,965	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	69,784	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	46,811	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	46,928	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	4,297	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	603	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			147,676	0	542,243	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	68	68	1,229	0	15,465	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	618	618	11,131	0	140,396	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	438	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	110,375	99	160,033		862,105	100.00
101.00	UNIT COST MULTIPLIER	160.896501	0.144315	0.999981		0.994394	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet O-6
Part II
Date/Time Prepared:
7/10/2020 2:50 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	686					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		686			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		123,648	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					114,098	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	68	0	68	0	950	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	618	0	618	0	8,600	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	139,177	0	93,360	0	93,593	100.00
101.00	UNIT COST MULTIPLIER	202.881924	0.000000	136.093294	0.000000	0.756931	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet O-6
Part II
Date/Time Prepared:
7/10/2020 2:50 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,901					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	1,571	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	6,368	0	0	0	1,450	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	53	0	0	0	12	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	480	0	0	0	109	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	8,570	0	0	0	1,203	100.00
101.00	UNIT COST MULTIPLIER	1.241849	0.000000	0.000000	0.000000	0.765754	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet O-6
Part II
Date/Time Prepared:
7/10/2020 2:50 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0042 Hospice CCN: 15-1526

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

Worksheet O-7

Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.274387	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.277122	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.527925	0	0	0	5.00
6.00	LABORATORY	60.00	0.140871	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1.058566	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.165256	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.639091	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	0	0	0	0	0	10.00
10.01	INPATIENT DIALYSIS	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2019 To 12/31/2019 | Worksheet O-8 | Date/Time Prepared: 7/10/2020 2:50 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,176,828	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			6,368	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			184.80	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	6,077	129		9.00
10.00	Program cost (line 8 times line 9)	1,123,030	23,839		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			54,687	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			53	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,031.83	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	22	0		14.00
15.00	Program cost (line 13 times line 14)	22,700	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			496,681	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			480	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			1,034.75	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	384	10		19.00
20.00	Program cost (line 18 times line 19)	397,344	10,348		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,728,196	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			6,901	22.00
23.00	Average cost per diem (line 21 divided by line 22)			250.43	23.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0042 | Period: From 01/01/2019 To 12/31/2019 | Worksheet L Parts I-III Date/Time Prepared: 7/10/2020 2:50 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,765,397	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	26,901	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)	49.63	3.00
4.00	Number of interns & residents (see instructions)	0.76	4.00
5.00	Indirect medical education percentage (see instructions)	0.43	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)	7,591	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,799,889	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