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: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/26/2020 11:24 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/26/2020 Time: 11:24 am
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 HUNTINGTON MEMORIAL HOSPITAL (15-0091) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

CFO
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	-8,972	39,336	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-8,972	39,336	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 11:24 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2001 STULTS ROAD	PO Box:			1.00
2.00	City: HUNTINGTON	State: IN	Zip Code: 46750	County: HUNTINGTON	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	HUNTINGTON MEMORIAL HOSPITAL	150091	99915	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	87	458	0	4	658	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 11:24 am

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

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

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	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.	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.	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.	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 11:24 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 11:24 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 11:24 am

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	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)			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/26/2020 11:24 am

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	101,381	0	59,786	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/26/2020 11:24 am

		1.00	2.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15HO32	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46895-5600	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 11:24 am

		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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/26/2020 11:24 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/25/2020	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	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)	N		N		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)	Y	04/30/2020	Y	04/30/2020	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.	Y		Y		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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/26/2020 11:24 am

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406	ERIC.NICKESON@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/26/2020 11:24 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/26/2020 11:24 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	36	13,140	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	13,140	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		36	13,140	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		36				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/26/2020 11:24 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,227	67	4,355			1.00
2.00	HMO and other (see instructions)	1,369	1,058				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,227	67	4,355			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		20	619			13.00
14.00	Total (see instructions)	1,227	87	4,974	0.00	2,684.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			91			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	2,684.00	27.00
28.00	Observation Bed Days		234	1,768			28.00
29.00	Ambulance Trips	1,793					29.00
30.00	Employee discount days (see instruction)			73			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	62	97			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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/26/2020 11:24 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	453	30	1,821	1.00
2.00	HMO and other (see instructions)			464	304		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	453	30	1,821	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II | Date/Time Prepared: 6/26/2020 11:24 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	16,347,199	5,100,671	21,447,870	614,371.67	34.91	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		24,000	0	24,000	106.00	226.42	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		5,100,671	0	5,100,671	130,526.47	39.08	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,633,599	345,631	2,979,230	73,321.20	40.63	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		5,100,671	0	5,100,671	130,526.47	39.08	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)		5,238,270	0	5,238,270			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,167,418	0	1,167,418			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,561,252	0	1,561,252			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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II | Date/Time Prepared: 6/26/2020 11:24 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
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	1,512,454	-1,512,454	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,517,125	5,136,514	6,653,639	146,171.88	45.52	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	336,029	38,717	374,746	13,988.10	26.79	30.00
31.00	Laundry & Linen Service	8.00	0	30,629	30,629	3,773.00	8.12	31.00
32.00	Housekeeping	9.00	292,813	3,108	295,921	17,963.13	16.47	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	417,626	-351,023	66,603	5,791.23	11.50	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	308,830	308,830	19,380.00	15.94	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	365,653	42,130	407,783	8,254.25	49.40	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	550,934	0	550,934	10,532.43	52.31	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 6/26/2020 11:24 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		11,246,528	5,100,671	16,347,199	483,845.20	33.79	1.00
2.00	Excluded area salaries (see instructions)		2,633,599	345,631	2,979,230	73,321.20	40.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)		8,612,929	4,755,040	13,367,969	410,524.00	32.56	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,100,671	0	5,100,671	130,526.47	39.08	4.00
5.00	Subtotal wage-related costs (see inst.)		6,799,522	0	6,799,522	0.00	50.86	5.00
6.00	Total (sum of lines 3 thru 5)		20,513,122	4,755,040	25,268,162	541,050.47	46.70	6.00
7.00	Total overhead cost (see instructions)		4,992,634	3,696,451	8,689,085	225,854.02	38.47	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 6/26/2020 11:24 am

		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	334,502	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,159,324	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	1,683	6.00
7.00	Employee Managed Care Program Administration Fees	49,768	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)	3,326,886	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	48,660	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)	67,722	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	19,711	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	1,300,957	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	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))	37,538	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	58,937	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,405,688	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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part V | Date/Time Prepared: 6/26/2020 11:24 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	6,405,688	1.00
2.00	Hospital	0	6,405,688	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/26/2020 11:24 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.219027	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,254,237	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	18,805,141	6.00
7.00	Medicaid cost (line 1 times line 6)	4,118,834	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,864,597	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	15,791	9.00
10.00	Stand-alone CHIP charges	28,087	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	6,152	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)	3,119,856	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	23,696,292	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	5,190,128	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	2,070,272	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)	3,934,869	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)	3,486,331	1,137,052	4,623,383	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	763,601	1,137,052	1,900,653	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,348	341	1,689	22.00
23.00	Cost of charity care (line 21 minus line 22)	762,253	1,136,711	1,898,964	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)	7,118,978	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	45,468	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	69,951	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,049,027	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,568,410	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,467,374	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,402,243	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,792,407	1,792,407	44,244	1,836,651	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,123,773	1,123,773	43,896	1,167,669	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,512,454	5,681,792	7,194,246	-1,512,454	5,681,792	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,517,125	21,558,803	23,075,928	-47,494	23,028,434	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	336,029	971,980	1,308,009	38,717	1,346,726	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	147,890	147,890	30,629	178,519	8.00
9.00	00900	HOUSEKEEPING	292,813	138,336	431,149	3,108	434,257	9.00
10.00	01000	DIETARY	417,626	311,404	729,030	-614,215	114,815	10.00
11.00	01100	CAFETERIA	0	0	0	540,367	540,367	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	365,653	6,087	371,740	42,130	413,870	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	550,934	142,135	693,069	0	693,069	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,283,769	613,847	3,897,616	-342,474	3,555,142	30.00
43.00	04300	NURSERY	0	0	0	153,939	153,939	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,044,255	551,052	1,595,307	129,500	1,724,807	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	578,908	578,908	52.00
53.00	05300	ANESTHESIOLOGY	0	950,029	950,029	0	950,029	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,337	561,707	1,578,044	117,100	1,695,144	54.00
60.00	06000	LABORATORY	0	2,578,959	2,578,959	0	2,578,959	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	731,986	112,405	844,391	84,338	928,729	65.00
66.00	06600	PHYSICAL THERAPY	1,246,060	81,991	1,328,051	-305,216	1,022,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	268,734	268,734	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	180,050	180,050	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,710,509	1,710,509	-778,303	932,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	778,303	778,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,378,824	2,378,824	63,477	2,442,301	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	178,277	318,652	496,929	0	496,929	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101,305	8,339	109,644	0	109,644	90.00
91.00	09100	EMERGENCY	1,118,977	287,681	1,406,658	130,233	1,536,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,556,071	405,341	2,961,412	294,505	3,255,917	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		4,803	4,803	-4,803	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,269,671	42,438,746	58,708,417	-82,781	58,625,636	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	72,453	72,453	0	72,453	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	77,528	11,889	89,417	8,933	98,350	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	205,133	205,133	0	205,133	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	364,962	364,962	0	364,962	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	73,848	73,848	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	16,347,199	43,093,183	59,440,382	0	59,440,382	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	173,187	2,009,838		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-73,667	1,094,002		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,577,565	2,104,227		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,132,733	16,895,701		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-1,457	1,345,269		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,519		8.00
9.00	00900	HOUSEKEEPING	0	434,257		9.00
10.00	01000	DIETARY	-3,801	111,014		10.00
11.00	01100	CAFETERIA	-242,671	297,696		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	413,870		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-173,757	519,312		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-7,756	3,547,386		30.00
43.00	04300	NURSERY	0	153,939		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-950,035	774,772		50.00
50.01	05001	OPERATING ROOM	0	0		50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	578,908		52.00
53.00	05300	ANESTHESIOLOGY	0	950,029		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,270	1,691,874		54.00
60.00	06000	LABORATORY	0	2,578,959		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	-29,530	899,199		65.00
66.00	06600	PHYSICAL THERAPY	-13,455	1,009,380		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	268,734		67.00
68.00	06800	SPEECH PATHOLOGY	0	180,050		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	932,206		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	778,303		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,442,301		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	496,929		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	109,644		90.00
91.00	09100	EMERGENCY	-39,314	1,497,577		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-14,461	3,241,456		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,090,285	47,535,351		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	72,453		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	98,350		192.00
194.00	07950	OCC HEALTH	0	0		194.00
194.01	07951	PAIN CLINIC	0	0		194.01
194.02	07952	OCC HEALTH	0	0		194.02
194.03	07953	FOUNDATIO	0	205,133		194.03
194.04	07954	KIDS CAMPUS	0	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	364,962		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0		194.06
194.07	07957	MISC CATERING	0	73,848		194.07
194.08	07958	AUTISM CENTER	0	0		194.08
194.09	07959	HUNTINGTON BUA	0	0		194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,090,285	48,350,097		200.00

RECLASSIFICATIONS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/26/2020 11:24 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA & CATERING				
1.00	CAFETERIA	11.00	308,830	231,537	1.00
2.00	MISC CATERING	194.07	42,193	31,655	2.00
	TOTALS		351,023	263,192	
	B - INTEREST RECLASSIFICATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,803	1.00
	TOTALS		0	4,803	
	C - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	44,244	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	39,093	2.00
	TOTALS		0	83,337	
	E - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	30,629	0	1.00
	TOTALS		30,629	0	
	F - HOME OFFICE SALARY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	5,100,671	0	1.00
	TOTALS		5,100,671	0	
	G - PTO & BENEFITS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	35,843	0	1.00
2.00	OPERATION OF PLANT	7.00	38,717	0	2.00
3.00	HOUSEKEEPING	9.00	33,737	0	3.00
4.00	NURSING ADMINISTRATION	13.00	42,130	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	390,373	0	5.00
6.00	OPERATING ROOM	50.00	129,500	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	117,100	0	7.00
8.00	RESPIRATORY THERAPY	65.00	84,338	0	8.00
9.00	PHYSICAL THERAPY	66.00	143,568	0	9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	63,477	0	10.00
11.00	EMERGENCY	91.00	130,233	0	11.00
12.00	AMBULANCE SERVICES	95.00	294,505	0	12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	8,933	0	13.00
	TOTALS		1,512,454	0	
	H - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	778,303	1.00
	TOTALS		0	778,303	
	I - OB RECLASS				
1.00	NURSERY	43.00	139,316	14,623	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	523,917	54,991	2.00
	TOTALS		663,233	69,614	
	J - THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	252,731	16,003	1.00
2.00	SPEECH PATHOLOGY	68.00	169,328	10,722	2.00
	TOTALS		422,059	26,725	
500.00	Grand Total: Increases		8,080,069	1,225,974	500.00

RECLASSIFICATIONS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/26/2020 11:24 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA & CATERING						
1.00	DIETARY	10.00	351,023	263,192	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		351,023	263,192			
	B - INTEREST RECLASSIFICATION						
1.00	INTEREST EXPENSE	113.00	0	4,803	11		1.00
	TOTALS		0	4,803			
	C - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,337	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	83,337			
	E - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	30,629	0	0		1.00
	TOTALS		30,629	0			
	F - HOME OFFICE SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,100,671	0		1.00
	TOTALS		0	5,100,671			
	G - PTO & BENEFITS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,512,454	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	TOTALS		1,512,454	0			
	H - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	778,303	0		1.00
	TOTALS		0	778,303			
	I - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	663,233	69,614	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		663,233	69,614			
	J - THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	422,059	26,725	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		422,059	26,725			
500.00	Grand Total: Decreases		2,979,398	6,326,645			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 6/26/2020 11:24 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	556,529	55,265	0	55,265	0	2.00
3.00	Buildings and Fixtures	2,370,508	6,892,707	0	6,892,707	0	3.00
4.00	Building Improvements	32,500	0	0	0	0	4.00
5.00	Fixed Equipment	1,783,863	397,140	0	397,140	0	5.00
6.00	Movable Equipment	12,232,194	1,217,029	0	1,217,029	535,998	6.00
7.00	HIT designated Assets	3,039,789	123,346	0	123,346	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,015,383	8,685,487	0	8,685,487	535,998	8.00
9.00	Reconciling Items	-3,496,947	6,427,163	0	6,427,163	0	9.00
10.00	Total (line 8 minus line 9)	23,512,330	2,258,324	0	2,258,324	535,998	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	611,794	187,814	2.00
3.00	Buildings and Fixtures	9,263,215	721,854	3.00
4.00	Building Improvements	32,500	0	4.00
5.00	Fixed Equipment	2,181,003	225,103	5.00
6.00	Movable Equipment	12,913,225	7,472,452	6.00
7.00	HIT designated Assets	3,163,135	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,164,872	8,607,223	8.00
9.00	Reconciling Items	2,930,216	0	9.00
10.00	Total (line 8 minus line 9)	25,234,656	8,607,223	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 6/26/2020 11:24 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	506,188	1,286,219	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,038,572	73,816	0	0	6,613	2.00
3.00	Total (sum of lines 1-2)	1,544,760	1,360,035	0	0	6,613	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,792,407		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,772	1,123,773		2.00
3.00	Total (sum of lines 1-2)	4,772	2,916,180		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III | Date/Time Prepared: 6/26/2020 11:24 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,088,511	0	12,088,511	0.487772	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,913,225	218,617	12,694,608	0.512228	0	2.00
3.00	Total (sum of lines 1-2)	25,001,736	218,617	24,783,119	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,971,889	-6,295	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	969,708	73,816	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,941,597	67,521	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	44,244	0	0	2,009,838	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	39,093	6,613	4,772	1,094,002	2.00
3.00	Total (sum of lines 1-2)	0	83,337	6,613	4,772	3,103,840	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/26/2020 11:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-4,803	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,025	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-257	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-982,998			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	-6,183,922			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-55,183	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/26/2020 11:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	TELEPHONE SERVICES	A	-333	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	RENT EXPENSE OFFSET	A	-984,267	CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	RENT EXPENSE OFFSET	A	-19,686	CAP REL COSTS-BLDG & FIXT	1.00	10	33.03
33.04	RENT EXPENSE OFFSET	A	-274,161	CAP REL COSTS-BLDG & FIXT	1.00	10	33.04
33.05	RENT EXPENSE OFFSET	A	-14,400	CAP REL COSTS-BLDG & FIXT	1.00	10	33.05
33.06	PHARMACY EMPLOYEE RX PURCHASES	B	-100,601	PHARMACY	15.00	0	33.06
33.07	PHYSICIAN RECRUITMENT	A	-25,000	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	SELF INSURANCE	A	-3,577,232	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	GUEST MEAL OFFSET	A	-9,353	CAFETERIA	11.00	0	33.09
33.10	AHA-IHA LOBBYING OFFSET	A	-4,424	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	LOBBYING OFFSET	A	-1,279	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	LIQUOR OFFSET	A	-562	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING REVENUE	B	-40,921	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING REVENUE	B	-3,801	DIETARY	10.00	0	33.14
33.15	OTHER OPERATING REVENUE	B	-178,135	CAFETERIA	11.00	0	33.15
33.16	OTHER OPERATING REVENUE	B	-73,156	PHARMACY	15.00	0	33.16
33.17	OTHER OPERATING REVENUE	B	-3,270	RADIOLOGY-DIAGNOSTIC	54.00	0	33.17
33.18	OTHER OPERATING REVENUE	B	-29,530	RESPIRATORY THERAPY	65.00	0	33.18
33.19	OTHER OPERATING REVENUE	B	-13,455	PHYSICAL THERAPY	66.00	0	33.19
33.20	OTHER OPERATING REVENUE	B	-16,814	EMERGENCY	91.00	0	33.20
33.21	OTHER OPERATING REVENUE	B	-1,350	AMBULANCE SERVICES	95.00	0	33.21
33.22	OTHER OPERATING REVENUE	B	-43,932	ADULTS & PEDIATRICS	30.00	0	33.22
33.23	OTHER OPERATING REVENUE	B	-2,648	OPERATING ROOM	50.00	0	33.23
33.24	OTHER OPERATING REVENUE	B	-1,200	OPERATION OF PLANT	7.00	0	33.24
33.25	DEPRECIATION	A	1,465,701	CAP REL COSTS-BLDG & FIXT	1.00	9	33.25
33.26	DEPRECIATION	A	-68,864	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.26
33.27	TELEMETRY COSTS	A	36,176	ADULTS & PEDIATRICS	30.00	0	33.27
33.28	PHYSICIAN ADMINISTRATION SALARIES	A	124,400	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,090,285				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/26/2020 11:24 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	11,246,587	8,989,332	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PPG SUBSIDY	0	8,441,177	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,246,587	17,430,509	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	PARKVIEW HEALTH SYSTEM, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/26/2020 11:24 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,257,255	0		1.00
2.00	-8,441,177	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-6,183,922			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/26/2020 11:24 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	DR. A	947,991	923,991	24,000	11,844	106	1.00
2.00	91.00	DR. B	22,500	22,500	0	0	0	2.00
3.00	95.00	DR. C	13,111	13,111	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			983,602	959,602	24,000		106	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	DR. A	604	30	0	0	0	1.00
2.00	91.00	DR. B	0	0	0	0	0	2.00
3.00	95.00	DR. C	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			604	30	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	DR. A	0	604	23,396	947,387		1.00
2.00	91.00	DR. B	0	0	0	22,500		2.00
3.00	95.00	DR. C	0	0	0	13,111		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	604	23,396	982,998		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/26/2020 11:24 am

		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	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,009,838	2,009,838				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,094,002		1,094,002			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,104,227	1,934	0	2,106,161		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,895,701	112,513	5,080	653,383	17,666,677	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,345,269	449,302	31,690	36,800	1,863,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	178,519	9,214	0	3,008	190,741	8.00
9.00	00900	HOUSEKEEPING	434,257	7,500	0	29,059	470,816	9.00
10.00	01000	DIETARY	111,014	71,659	2,122	6,540	191,335	10.00
11.00	01100	CAFETERIA	297,696	16,260	0	30,327	344,283	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	413,870	0	0	40,044	453,914	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,905	0	0	27,905	14.00
15.00	01500	PHARMACY	519,312	16,919	85,936	54,101	676,268	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,346	0	0	9,346	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,547,386	368,549	142,554	295,668	4,354,157	30.00
43.00	04300	NURSERY	153,939	1,494	0	13,681	169,114	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	774,772	140,389	172,928	115,262	1,203,351	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	578,908	0	0	51,448	630,356	52.00
53.00	05300	ANESTHESIOLOGY	950,029	0	0	0	950,029	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,691,874	175,954	246,900	111,302	2,226,030	54.00
60.00	06000	LABORATORY	2,578,959	26,660	0	0	2,605,619	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	899,199	32,255	48,542	80,162	1,060,158	65.00
66.00	06600	PHYSICAL THERAPY	1,009,380	381,352	34,078	95,014	1,519,824	66.00
67.00	06700	OCCUPATIONAL THERAPY	268,734	0	0	24,818	293,552	67.00
68.00	06800	SPEECH PATHOLOGY	180,050	0	0	16,628	196,678	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	932,206	0	0	0	932,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	778,303	0	0	0	778,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,442,301	0	0	6,233	2,448,534	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	496,929	29,575	0	17,507	544,011	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	109,644	0	0	9,948	119,592	90.00
91.00	09100	EMERGENCY	1,497,577	74,999	25,703	122,671	1,720,950	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,241,456	52,016	297,241	279,924	3,870,637	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,535,351	2,005,795	1,092,774	2,093,528	47,517,447	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,453	0	0	0	72,453	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	98,350	0	1,228	8,490	108,068	192.00
194.00	07950	OCC HEALTH	0	4,043	0	0	4,043	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	205,133	0	0	0	205,133	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	364,962	0	0	0	364,962	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	73,848	0	0	4,143	77,991	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	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)	48,350,097	2,009,838	1,094,002	2,106,161	48,350,097	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,666,677					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,072,700	0	2,935,761			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,824	0	18,705	319,270		8.00
9.00	00900	HOUSEKEEPING	271,083	0	15,226	0	757,125	9.00
10.00	01000	DIETARY	110,166	0	145,478	0	37,957	10.00
11.00	01100	CAFETERIA	198,229	0	33,009	0	8,613	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	261,351	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,067	0	56,651	636	14,781	14.00
15.00	01500	PHARMACY	389,377	0	34,347	0	8,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,381	0	18,973	0	4,950	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,506,998	0	748,207	94,609	195,217	30.00
43.00	04300	NURSERY	97,371	0	3,033	4,705	791	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	692,857	0	285,009	46,642	74,362	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	362,942	0	0	18,776	0	52.00
53.00	05300	ANESTHESIOLOGY	547,001	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,281,688	0	357,212	38,070	93,201	54.00
60.00	06000	LABORATORY	1,500,245	0	54,123	0	14,121	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	610,410	0	65,483	22,527	17,085	65.00
66.00	06600	PHYSICAL THERAPY	875,074	0	774,199	0	202,001	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,019	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	113,242	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	536,739	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	448,126	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,409,800	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	313,227	0	60,041	0	15,665	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	68,858	0	0	0	0	90.00
91.00	09100	EMERGENCY	990,877	0	152,258	79,176	39,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,228,608	0	105,599	6,566	27,552	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,187,260	0	2,927,553	311,707	754,984	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	41,716	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	62,223	0	0	7,563	0	192.00
194.00	07950	OCC HEALTH	2,328	0	8,208	0	2,141	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	118,110	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	210,135	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	44,905	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	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)	17,666,677	0	2,935,761	319,270	757,125	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	484,936					10.00
11.00	01100	CAFETERIA	0	584,134				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	9,386	0	724,651		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	116,040	14.00
15.00	01500	PHARMACY	0	14,717	0	0	1,369	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	484,936	188,008	0	430,736	8,159	30.00
43.00	04300	NURSERY	0	5,943	0	13,617	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,981	0	98,471	11,985	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,721	0	54,345	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,314	0	0	2,965	54.00
60.00	06000	LABORATORY	0	0	0	0	48	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	37,688	0	0	4,572	65.00
66.00	06600	PHYSICAL THERAPY	0	35,288	0	0	1,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,244	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,014	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	68,107	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	2,114	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	227	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	55,644	0	127,482	6,636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	98,289	0	0	8,185	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	484,936	572,237	0	724,651	115,904	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	5,459	0	0	127	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	4,104	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	9	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	2,334	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	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)	484,936	584,134	0	724,651	116,040	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,125,040					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,650				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,044	2,841	0	0	0	30.00
43.00	04300	NURSERY	0	193	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	117,581	4,975	0	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	738	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	648	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,092	6,585	0	0	0	54.00
60.00	06000	LABORATORY	472	4,759	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	44,853	1,529	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	15,075	998	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	349	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	136	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	168	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	668,214	1,032	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	770	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,740	3,723	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,225	470	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	154	0	0	0	90.00
91.00	09100	EMERGENCY	65,107	5,489	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	80,305	3,093	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,123,708	38,650	0	0	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	1,249	0	0	0	0	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	83	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,125,040	38,650	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	9,093,912	0	30.00
43.00	04300	NURSERY	0	0	0	294,767	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,578,214	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,090,878	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,497,678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,081,157	0	54.00
60.00	06000	LABORATORY	0	0	0	4,179,387	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,864,305	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,423,996	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	474,164	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	313,070	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	168	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,206,298	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,227,199	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,884,911	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	935,866	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	188,604	0	90.00
91.00	09100	EMERGENCY	0	0	0	3,243,345	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	6,428,834	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	47,006,753	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	114,169	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	184,689	0	192.00
194.00	07950	OCC HEALTH	0	0	0	16,720	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	327,347	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	575,189	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	125,230	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments	0	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)	0	0	0	48,350,097	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	9,093,912		30.00
43.00	04300	NURSERY	294,767		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,578,214		50.00
50.01	05001	OPERATING ROOM	0		50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,090,878		52.00
53.00	05300	ANESTHESIOLOGY	1,497,678		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,081,157		54.00
60.00	06000	LABORATORY	4,179,387		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	1,864,305		65.00
66.00	06600	PHYSICAL THERAPY	3,423,996		66.00
67.00	06700	OCCUPATIONAL THERAPY	474,164		67.00
68.00	06800	SPEECH PATHOLOGY	313,070		68.00
69.00	06900	ELECTROCARDIOLOGY	168		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,206,298		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,227,199		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,884,911		73.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	935,866		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	188,604		90.00
91.00	09100	EMERGENCY	3,243,345		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	6,428,834		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,006,753		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	114,169		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	184,689		192.00
194.00	07950	OCC HEALTH	16,720		194.00
194.01	07951	PAIN CLINIC	0		194.01
194.02	07952	OCC HEALTH	0		194.02
194.03	07953	FOUNDATIO	327,347		194.03
194.04	07954	KIDS CAMPUS	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	575,189		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0		194.06
194.07	07957	MISC CATERING	125,230		194.07
194.08	07958	AUTISM CENTER	0		194.08
194.09	07959	HUNTINGTON BUA	0		194.09
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	48,350,097		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,934	0	1,934	1,934	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,900,923	112,513	5,080	2,018,516	600	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	449,302	31,690	480,992	34	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,214	0	9,214	3	8.00
9.00	00900	HOUSEKEEPING	0	7,500	0	7,500	27	9.00
10.00	01000	DIETARY	0	71,659	2,122	73,781	6	10.00
11.00	01100	CAFETERIA	0	16,260	0	16,260	28	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	37	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,905	0	27,905	0	14.00
15.00	01500	PHARMACY	0	16,919	85,936	102,855	50	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,346	0	9,346	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	368,549	142,554	511,103	271	30.00
43.00	04300	NURSERY	0	1,494	0	1,494	13	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	140,389	172,928	313,317	106	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	47	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	175,954	246,900	422,854	102	54.00
60.00	06000	LABORATORY	0	26,660	0	26,660	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	32,255	48,542	80,797	73	65.00
66.00	06600	PHYSICAL THERAPY	0	381,352	34,078	415,430	87	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	23	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	15	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	29,575	0	29,575	16	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	9	90.00
91.00	09100	EMERGENCY	0	74,999	25,703	100,702	112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	52,016	297,241	349,257	257	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,900,923	2,005,795	1,092,774	4,999,492	1,922	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,228	1,228	8	192.00
194.00	07950	OCC HEALTH	0	4,043	0	4,043	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	4	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	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)	1,900,923	2,009,838	1,094,002	5,004,763	1,934	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,019,116					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	122,599	0	603,625			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,552	0	3,846	25,615		8.00
9.00	00900	HOUSEKEEPING	30,982	0	3,131	0	41,640	9.00
10.00	01000	DIETARY	12,591	0	29,912	0	2,088	10.00
11.00	01100	CAFETERIA	22,656	0	6,787	0	474	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	29,870	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,836	0	11,648	51	813	14.00
15.00	01500	PHARMACY	44,502	0	7,062	0	493	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	615	0	3,901	0	272	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	286,516	0	153,840	7,592	10,736	30.00
43.00	04300	NURSERY	11,129	0	624	377	44	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,187	0	58,601	3,742	4,090	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,481	0	0	1,506	0	52.00
53.00	05300	ANESTHESIOLOGY	62,517	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146,484	0	73,447	3,054	5,126	54.00
60.00	06000	LABORATORY	171,463	0	11,128	0	777	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	69,764	0	13,464	1,807	940	65.00
66.00	06600	PHYSICAL THERAPY	100,012	0	159,183	0	11,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,317	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,942	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,344	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,216	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	161,126	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	35,799	0	12,345	0	862	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,870	0	0	0	0	90.00
91.00	09100	EMERGENCY	113,247	0	31,306	6,352	2,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	254,707	0	21,712	527	1,515	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,964,324	0	601,937	25,008	41,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,768	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,111	0	0	607	0	192.00
194.00	07950	OCC HEALTH	266	0	1,688	0	118	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	13,499	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	24,016	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	5,132	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	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)	2,019,116	0	603,625	25,615	41,640	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	118,378					10.00
11.00	01100	CAFETERIA	0	46,205				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	742	0	30,649		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	42,253	14.00
15.00	01500	PHARMACY	0	1,164	0	0	498	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	118,378	14,873	0	18,217	2,971	30.00
43.00	04300	NURSERY	0	470	0	576	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,400	0	4,165	4,364	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,876	0	2,299	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,663	0	0	1,080	54.00
60.00	06000	LABORATORY	0	0	0	0	18	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,981	0	0	1,665	65.00
66.00	06600	PHYSICAL THERAPY	0	2,791	0	0	559	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	889	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	238	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	24,800	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	770	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	83	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	4,401	0	5,392	2,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,775	0	0	2,980	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118,378	45,263	0	30,649	42,204	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	432	0	0	46	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	325	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	3	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	185	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	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)	118,378	46,205	0	30,649	42,253	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	156,624					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,134				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,143	1,042	0			30.00
43.00	04300	NURSERY	0	71	0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,369	1,824	0			50.00
50.01	05001	OPERATING ROOM	0	0	0			50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	270	0			52.00
53.00	05300	ANESTHESIOLOGY	0	238	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,050	2,379	0			54.00
60.00	06000	LABORATORY	66	1,745	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	6,244	560	0			65.00
66.00	06600	PHYSICAL THERAPY	2,099	366	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	128	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	50	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	61	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	93,026	378	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	282	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,887	1,365	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	310	172	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	56	0			90.00
91.00	09100	EMERGENCY	9,064	2,013	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	11,180	1,134	0			95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	156,438	14,134	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	174	0	0			192.00
194.00	07950	OCC HEALTH	0	0	0			194.00
194.01	07951	PAIN CLINIC	0	0	0			194.01
194.02	07952	OCC HEALTH	0	0	0			194.02
194.03	07953	FOUNDATIO	0	0	0			194.03
194.04	07954	KIDS CAMPUS	0	0	0			194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	12	0	0			194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0			194.06
194.07	07957	MISC CATERING	0	0	0			194.07
194.08	07958	AUTISM CENTER	0	0	0			194.08
194.09	07959	HUNTINGTON BUA	0	0	0			194.09
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	156,624	14,134	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	INTERNS & RESIDENTS: SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS: SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				1,136,682	0	30.00
43.00	04300	NURSERY				14,798	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				489,165	0	50.00
50.01	05001	OPERATING ROOM				0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM				47,479	0	52.00
53.00	05300	ANESTHESIOLOGY				62,755	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				662,239	0	54.00
60.00	06000	LABORATORY				211,857	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				178,295	0	65.00
66.00	06600	PHYSICAL THERAPY				691,634	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				20,357	0	67.00
68.00	06800	SPEECH PATHOLOGY				13,245	0	68.00
69.00	06900	ELECTROCARDIOLOGY				61	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				179,548	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				51,498	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				166,154	0	73.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				79,162	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC				7,935	0	90.00
91.00	09100	EMERGENCY				277,190	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				651,044	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	4,941,098	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				4,768	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				9,606	0	192.00
194.00	07950	OCC HEALTH				6,115	0	194.00
194.01	07951	PAIN CLINIC				0	0	194.01
194.02	07952	OCC HEALTH				0	0	194.02
194.03	07953	FOUNDATIO				13,824	0	194.03
194.04	07954	KIDS CAMPUS				0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES				24,031	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE				0	0	194.06
194.07	07957	MISC CATERING				5,321	0	194.07
194.08	07958	AUTISM CENTER				0	0	194.08
194.09	07959	HUNTINGTON BUA				0	0	194.09
200.00		Cross Foot Adjustments	0	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)	0	0	0	5,004,763	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,136,682		30.00
43.00	04300	NURSERY	14,798		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	489,165		50.00
50.01	05001	OPERATING ROOM	0		50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,479		52.00
53.00	05300	ANESTHESIOLOGY	62,755		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,239		54.00
60.00	06000	LABORATORY	211,857		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	178,295		65.00
66.00	06600	PHYSICAL THERAPY	691,634		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,357		67.00
68.00	06800	SPEECH PATHOLOGY	13,245		68.00
69.00	06900	ELECTROCARDIOLOGY	61		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	179,548		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,498		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	166,154		73.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	79,162		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	7,935		90.00
91.00	09100	EMERGENCY	277,190		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	651,044		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,941,098		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,768		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,606		192.00
194.00	07950	OCC HEALTH	6,115		194.00
194.01	07951	PAIN CLINIC	0		194.01
194.02	07952	OCC HEALTH	0		194.02
194.03	07953	FOUNDATIO	13,824		194.03
194.04	07954	KIDS CAMPUS	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	24,031		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0		194.06
194.07	07957	MISC CATERING	5,321		194.07
194.08	07958	AUTISM CENTER	0		194.08
194.09	07959	HUNTINGTON BUA	0		194.09
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	5,004,763		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	137,207					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		724,209				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	21,447,870			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,681	3,363	6,653,639	-17,666,677	30,683,420	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	30,673	20,978	374,746	0	1,863,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	629	0	30,629	0	190,741	8.00
9.00	00900	HOUSEKEEPING	512	0	295,921	0	470,816	9.00
10.00	01000	DIETARY	4,892	1,405	66,603	0	191,335	10.00
11.00	01100	CAFETERIA	1,110	0	308,830	0	344,283	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	407,783	0	453,914	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,905	0	0	0	27,905	14.00
15.00	01500	PHARMACY	1,155	56,888	550,934	0	676,268	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	638	0	0	0	9,346	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,160	94,368	3,010,909	0	4,354,157	30.00
43.00	04300	NURSERY	102	0	139,316	0	169,114	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,584	114,475	1,173,755	0	1,203,351	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	523,917	0	630,356	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	950,029	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,012	163,443	1,133,437	0	2,226,030	54.00
60.00	06000	LABORATORY	1,820	0	0	0	2,605,619	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,202	32,134	816,324	0	1,060,158	65.00
66.00	06600	PHYSICAL THERAPY	26,034	22,559	967,569	0	1,519,824	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	252,731	0	293,552	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	169,328	0	196,678	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	932,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	778,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	63,477	0	2,448,534	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,019	0	178,277	0	544,011	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	101,305	0	119,592	90.00
91.00	09100	EMERGENCY	5,120	17,015	1,249,210	0	1,720,950	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,551	196,768	2,850,576	0	3,870,637	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,931	723,396	21,319,216	-17,666,677	29,850,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	72,453	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	813	86,461	0	108,068	192.00
194.00	07950	OCC HEALTH	276	0	0	0	4,043	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	205,133	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	364,962	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	42,193	0	77,991	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,009,838	1,094,002	2,106,161		17,666,677	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.648218	1.510616	0.098199		0.575773	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,934		2,019,116	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000090		0.065805	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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	98,721				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	629	257,000			8.00
9.00	00900	HOUSEKEEPING	0	512	0	97,580		9.00
10.00	01000	DIETARY	0	4,892	0	4,892	22,839	10.00
11.00	01100	CAFETERIA	0	1,110	0	1,110	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,905	512	1,905	0	14.00
15.00	01500	PHARMACY	0	1,155	0	1,155	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	638	0	638	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,160	76,157	25,160	22,839	30.00
43.00	04300	NURSERY	0	102	3,787	102	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,584	37,545	9,584	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	15,114	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,012	30,645	12,012	0	54.00
60.00	06000	LABORATORY	0	1,820	0	1,820	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,202	18,133	2,202	0	65.00
66.00	06600	PHYSICAL THERAPY	0	26,034	0	26,034	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,019	0	2,019	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	5,120	63,734	5,120	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,551	5,285	3,551	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	98,445	250,912	97,304	22,839	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	0	0	6,088	0	0	192.00
194.00	07950	OCC HEALTH	0	276	0	276	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	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)	0	2,935,761	319,270	757,125	484,936	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	29.737958	1.242296	7.759018	21.232804	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	603,625	25,615	41,640	118,378	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	6.114454	0.099669	0.426727	5.183152	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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	405,214					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	6,511	0	219,416			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,850,056		14.00
15.00	01500	PHARMACY	10,209	0	0	33,612	2,816,445	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	130,422	0	130,422	200,383	200,383	30.00
43.00	04300	NURSERY	4,123	0	4,123	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,816	0	29,816	294,354	294,354	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,455	0	16,455	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,128	0	0	72,829	72,829	54.00
60.00	06000	LABORATORY	0	0	0	1,181	1,181	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	26,144	0	0	112,285	112,285	65.00
66.00	06600	PHYSICAL THERAPY	24,479	0	0	37,739	37,739	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,800	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,091	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,672,821	1,672,821	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	51,920	51,920	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	5,569	5,570	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	38,600	0	38,600	162,990	162,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	68,183	0	0	201,038	201,038	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	396,961	0	219,416	2,846,721	2,813,110	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	3,787	0	0	3,126	3,126	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	2,847	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	209	209	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	1,619	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	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)	584,134	0	724,651	116,040	1,125,040	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.441544	0.000000	3.302635	0.040715	0.399454	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	46,205	0	30,649	42,253	156,624	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.114026	0.000000	0.139684	0.014825	0.055611	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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	214,616,429					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,782,537	0	0	0	0	30.00
43.00	04300	NURSERY	1,074,564	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,637,007	0	0	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,098,130	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,599,291	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,499,479	0	0	0	0	54.00
60.00	06000	LABORATORY	26,438,766	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,491,803	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,542,815	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,937,154	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	755,491	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	931,347	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,730,698	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,277,203	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,680,647	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,613,035	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	853,342	0	0	0	0	90.00
91.00	09100	EMERGENCY	30,492,461	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	17,180,659	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,616,429	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	38,650	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000180	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,134	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000066	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
50.01	05001	OPERATING ROOM	0	0		50.01
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
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OCC HEALTH	0	0		194.00
194.01	07951	PAIN CLINIC	0	0		194.01
194.02	07952	OCC HEALTH	0	0		194.02
194.03	07953	FOUNDATIO	0	0		194.03
194.04	07954	KIDS CAMPUS	0	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0		194.06
194.07	07957	MISC CATERING	0	0		194.07
194.08	07958	AUTISM CENTER	0	0		194.08
194.09	07959	HUNTINGTON BUA	0	0		194.09
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/26/2020 11:24 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,093,912		9,093,912	0	9,093,912	30.00
43.00	04300	NURSERY	294,767		294,767	0	294,767	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,578,214		2,578,214	23,396	2,601,610	50.00
50.01	05001	OPERATING ROOM	0		0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,090,878		1,090,878	0	1,090,878	52.00
53.00	05300	ANESTHESIOLOGY	1,497,678		1,497,678	0	1,497,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,081,157		4,081,157	0	4,081,157	54.00
60.00	06000	LABORATORY	4,179,387		4,179,387	0	4,179,387	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,864,305	0	1,864,305	0	1,864,305	65.00
66.00	06600	PHYSICAL THERAPY	3,423,996	0	3,423,996	0	3,423,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	474,164	0	474,164	0	474,164	67.00
68.00	06800	SPEECH PATHOLOGY	313,070	0	313,070	0	313,070	68.00
69.00	06900	ELECTROCARDIOLOGY	168		168	0	168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,206,298		2,206,298	0	2,206,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,227,199		1,227,199	0	1,227,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,884,911		3,884,911	0	3,884,911	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	935,866		935,866	0	935,866	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	188,604		188,604	0	188,604	90.00
91.00	09100	EMERGENCY	3,243,345		3,243,345	0	3,243,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,625,851		2,625,851		2,625,851	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,428,834		6,428,834	0	6,428,834	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	49,632,604	0	49,632,604	23,396	49,656,000	200.00
201.00		Less Observation Beds	2,625,851		2,625,851		2,625,851	201.00
202.00		Total (see instructions)	47,006,753	0	47,006,753	23,396	47,030,149	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,864,402		9,864,402			30.00
43.00	04300	NURSERY	1,074,564		1,074,564			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,994,991	19,642,016	27,637,007	0.093288	0.000000	50.00
50.01	05001	OPERATING ROOM	0	0	0	0.000000	0.000000	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,098,130	0	4,098,130	0.266189	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	640,276	2,959,015	3,599,291	0.416104	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,878,153	32,621,326	36,499,479	0.111814	0.000000	54.00
60.00	06000	LABORATORY	5,292,020	21,146,746	26,438,766	0.158078	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,697,261	6,794,542	8,491,803	0.219542	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	562,729	4,980,086	5,542,815	0.617736	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,181	1,714,973	1,937,154	0.244774	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	37,590	717,901	755,491	0.414393	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	581,015	350,332	931,347	0.000180	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,461,396	4,269,302	5,730,698	0.384996	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,690,686	2,586,517	4,277,203	0.286916	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,397,116	15,283,531	20,680,647	0.187852	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	87,597	2,525,438	2,613,035	0.358153	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,504	851,838	853,342	0.221018	0.000000	90.00
91.00	09100	EMERGENCY	4,098,089	26,394,372	30,492,461	0.106365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,918,135	5,918,135	0.443696	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,180,659	17,180,659	0.374190	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	48,679,700	165,936,729	214,616,429			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	48,679,700	165,936,729	214,616,429			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.094135		50.00
50.01	05001	OPERATING ROOM	0.000000		50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.266189		52.00
53.00	05300	ANESTHESIOLOGY	0.416104		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111814		54.00
60.00	06000	LABORATORY	0.158078		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.219542		65.00
66.00	06600	PHYSICAL THERAPY	0.617736		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244774		67.00
68.00	06800	SPEECH PATHOLOGY	0.414393		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000180		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.384996		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286916		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187852		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.358153		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.221018		90.00
91.00	09100	EMERGENCY	0.106365		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.443696		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.374190		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,093,912		9,093,912	0	9,093,912	30.00
43.00	04300	NURSERY	294,767		294,767	0	294,767	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,578,214		2,578,214	23,396	2,601,610	50.00
50.01	05001	OPERATING ROOM	0		0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,090,878		1,090,878	0	1,090,878	52.00
53.00	05300	ANESTHESIOLOGY	1,497,678		1,497,678	0	1,497,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,081,157		4,081,157	0	4,081,157	54.00
60.00	06000	LABORATORY	4,179,387		4,179,387	0	4,179,387	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,864,305	0	1,864,305	0	1,864,305	65.00
66.00	06600	PHYSICAL THERAPY	3,423,996	0	3,423,996	0	3,423,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	474,164	0	474,164	0	474,164	67.00
68.00	06800	SPEECH PATHOLOGY	313,070	0	313,070	0	313,070	68.00
69.00	06900	ELECTROCARDIOLOGY	168		168	0	168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,206,298		2,206,298	0	2,206,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,227,199		1,227,199	0	1,227,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,884,911		3,884,911	0	3,884,911	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	935,866		935,866	0	935,866	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	188,604		188,604	0	188,604	90.00
91.00	09100	EMERGENCY	3,243,345		3,243,345	0	3,243,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,625,851		2,625,851		2,625,851	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,428,834		6,428,834	0	6,428,834	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	49,632,604	0	49,632,604	23,396	49,656,000	200.00
201.00		Less Observation Beds	2,625,851		2,625,851		2,625,851	201.00
202.00		Total (see instructions)	47,006,753	0	47,006,753	23,396	47,030,149	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,864,402		9,864,402			30.00
43.00	04300	NURSERY	1,074,564		1,074,564			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,994,991	19,642,016	27,637,007	0.093288	0.000000	50.00
50.01	05001	OPERATING ROOM	0	0	0	0.000000	0.000000	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,098,130	0	4,098,130	0.266189	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	640,276	2,959,015	3,599,291	0.416104	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,878,153	32,621,326	36,499,479	0.111814	0.000000	54.00
60.00	06000	LABORATORY	5,292,020	21,146,746	26,438,766	0.158078	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,697,261	6,794,542	8,491,803	0.219542	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	562,729	4,980,086	5,542,815	0.617736	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,181	1,714,973	1,937,154	0.244774	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	37,590	717,901	755,491	0.414393	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	581,015	350,332	931,347	0.000180	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,461,396	4,269,302	5,730,698	0.384996	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,690,686	2,586,517	4,277,203	0.286916	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,397,116	15,283,531	20,680,647	0.187852	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	87,597	2,525,438	2,613,035	0.358153	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,504	851,838	853,342	0.221018	0.000000	90.00
91.00	09100	EMERGENCY	4,098,089	26,394,372	30,492,461	0.106365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,918,135	5,918,135	0.443696	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,180,659	17,180,659	0.374190	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	48,679,700	165,936,729	214,616,429			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	48,679,700	165,936,729	214,616,429			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.094135		50.00
50.01	05001	OPERATING ROOM	0.000000		50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.266189		52.00
53.00	05300	ANESTHESIOLOGY	0.416104		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111814		54.00
60.00	06000	LABORATORY	0.158078		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.219542		65.00
66.00	06600	PHYSICAL THERAPY	0.617736		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244774		67.00
68.00	06800	SPEECH PATHOLOGY	0.414393		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000180		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.384996		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286916		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187852		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.358153		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.221018		90.00
91.00	09100	EMERGENCY	0.106365		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.443696		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.374190		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,578,214	489,165	2,089,049	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,090,878	47,479	1,043,399	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,497,678	62,755	1,434,923	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,081,157	662,239	3,418,918	0	0	54.00
60.00	06000	LABORATORY	4,179,387	211,857	3,967,530	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,864,305	178,295	1,686,010	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,423,996	691,634	2,732,362	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	474,164	20,357	453,807	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	313,070	13,245	299,825	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	168	61	107	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,206,298	179,548	2,026,750	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,227,199	51,498	1,175,701	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,884,911	166,154	3,718,757	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	935,866	79,162	856,704	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	188,604	7,935	180,669	0	0	90.00
91.00	09100	EMERGENCY	3,243,345	277,190	2,966,155	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,625,851	328,216	2,297,635	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,428,834	651,044	5,777,790	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	40,243,925	4,117,834	36,126,091	0	0	200.00
201.00		Less Observation Beds	2,625,851	328,216	2,297,635	0	0	201.00
202.00		Total (line 200 minus line 201)	37,618,074	3,789,618	33,828,456	0	0	202.00

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

Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,578,214	27,637,007	0.093288		50.00
50.01	05001	OPERATING ROOM	0	0	0.000000		50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,090,878	4,098,130	0.266189		52.00
53.00	05300	ANESTHESIOLOGY	1,497,678	3,599,291	0.416104		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,081,157	36,499,479	0.111814		54.00
60.00	06000	LABORATORY	4,179,387	26,438,766	0.158078		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	1,864,305	8,491,803	0.219542		65.00
66.00	06600	PHYSICAL THERAPY	3,423,996	5,542,815	0.617736		66.00
67.00	06700	OCCUPATIONAL THERAPY	474,164	1,937,154	0.244774		67.00
68.00	06800	SPEECH PATHOLOGY	313,070	755,491	0.414393		68.00
69.00	06900	ELECTROCARDIOLOGY	168	931,347	0.000180		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,206,298	5,730,698	0.384996		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,227,199	4,277,203	0.286916		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,884,911	20,680,647	0.187852		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	935,866	2,613,035	0.358153		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	188,604	853,342	0.221018		90.00
91.00	09100	EMERGENCY	3,243,345	30,492,461	0.106365		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,625,851	5,918,135	0.443696		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	6,428,834	17,180,659	0.374190		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	40,243,925	203,677,463			200.00
201.00		Less Observation Beds	2,625,851	0			201.00
202.00		Total (line 200 minus line 201)	37,618,074	203,677,463			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,136,682	0	1,136,682	6,123	185.64	30.00
43.00	NURSERY	14,798		14,798	619	23.91	43.00
200.00	Total (lines 30 through 199)	1,151,480		1,151,480	6,742		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,227	227,780	30.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	1,227	227,780	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	489,165	27,637,007	0.017700	1,469,782	26,015	50.00
50.01	05001	OPERATING ROOM	0	0	0.000000	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,479	4,098,130	0.011586	0	0	52.00
53.00	05300	ANESTHESIOLOGY	62,755	3,599,291	0.017435	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,239	36,499,479	0.018144	1,320,659	23,962	54.00
60.00	06000	LABORATORY	211,857	26,438,766	0.008013	1,494,243	11,973	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	178,295	8,491,803	0.020996	562,405	11,808	65.00
66.00	06600	PHYSICAL THERAPY	691,634	5,542,815	0.124780	192,119	23,973	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,357	1,937,154	0.010509	75,652	795	67.00
68.00	06800	SPEECH PATHOLOGY	13,245	755,491	0.017532	13,555	238	68.00
69.00	06900	ELECTROCARDIOLOGY	61	931,347	0.000065	230,487	15	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	179,548	5,730,698	0.031331	526,080	16,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,498	4,277,203	0.012040	691,574	8,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	166,154	20,680,647	0.008034	1,453,769	11,680	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	79,162	2,613,035	0.030295	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,935	853,342	0.009299	0	0	90.00
91.00	09100	EMERGENCY	277,190	30,492,461	0.009090	1,256,742	11,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	328,216	5,918,135	0.055459	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,466,790	186,496,804		9,287,067	146,693	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,123	0.00	1,227	30.00
43.00	04300	NURSERY		0	619	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	6,742		1,227	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
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	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	27,637,007	0.000000	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0.000000	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,098,130	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,599,291	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,499,479	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	26,438,766	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,491,803	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,542,815	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,937,154	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	755,491	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	931,347	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,730,698	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,277,203	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,680,647	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	2,613,035	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	853,342	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,492,461	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,918,135	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	186,496,804		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,469,782	0	4,377,962	0	50.00
50.01	05001	OPERATING ROOM	0.000000	0	0	0	0	50.01
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	0.000000	1,320,659	0	7,090,754	0	54.00
60.00	06000	LABORATORY	0.000000	1,494,243	0	482,039	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	562,405	0	1,105,968	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	192,119	0	114,443	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	75,652	0	30,990	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	13,555	0	6,224	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	230,487	0	273,830	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	526,080	0	780,061	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	691,574	0	406,435	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,453,769	0	4,613,938	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,256,742	0	4,098,471	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	1,626,364	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		9,287,067	0	25,007,479	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.093288	4,377,962	0	0	408,411	50.00
50.01	05001	OPERATING ROOM	0.000000	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.266189	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.416104	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111814	7,090,754	0	0	792,846	54.00
60.00	06000	LABORATORY	0.158078	482,039	0	0	76,200	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.219542	1,105,968	0	0	242,806	65.00
66.00	06600	PHYSICAL THERAPY	0.617736	114,443	0	0	70,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244774	30,990	0	0	7,586	67.00
68.00	06800	SPEECH PATHOLOGY	0.414393	6,224	0	0	2,579	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000180	273,830	0	0	49	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.384996	780,061	0	0	300,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286916	406,435	0	0	116,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187852	4,613,938	0	0	866,737	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.358153	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.221018	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.106365	4,098,471	0	0	435,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.443696	1,626,364	0	0	721,611	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.374190		0			95.00
200.00		Subtotal (see instructions)		25,007,479	0	0	4,042,388	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		25,007,479	0	0	4,042,388	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
50.01	05001	OPERATING ROOM	0	0		50.01
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
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,136,682	0	1,136,682	6,123	185.64	30.00
43.00	NURSERY	14,798		14,798	619	23.91	43.00
200.00	Total (lines 30 through 199)	1,151,480		1,151,480	6,742		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	67	12,438	30.00
43.00	NURSERY	20	478	43.00
200.00	Total (lines 30 through 199)	87	12,916	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	489,165	27,637,007	0.017700	233,843	4,139	50.00
50.01	05001	OPERATING ROOM	0	0	0.000000	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,479	4,098,130	0.011586	77,928	903	52.00
53.00	05300	ANESTHESIOLOGY	62,755	3,599,291	0.017435	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,239	36,499,479	0.018144	60,568	1,099	54.00
60.00	06000	LABORATORY	211,857	26,438,766	0.008013	100,615	806	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	178,295	8,491,803	0.020996	20,154	423	65.00
66.00	06600	PHYSICAL THERAPY	691,634	5,542,815	0.124780	1,264	158	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,357	1,937,154	0.010509	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,245	755,491	0.017532	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	61	931,347	0.000065	7,928	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	179,548	5,730,698	0.031331	23,071	723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,498	4,277,203	0.012040	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	166,154	20,680,647	0.008034	89,384	718	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	79,162	2,613,035	0.030295	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,935	853,342	0.009299	0	0	90.00
91.00	09100	EMERGENCY	277,190	30,492,461	0.009090	73,264	666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	328,216	5,918,135	0.055459	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,466,790	186,496,804		688,019	9,636	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,123	0.00	67	30.00
43.00	04300	NURSERY		0	619	0.00	20	43.00
200.00		Total (lines 30 through 199)		0	6,742		87	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
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	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	27,637,007	0.000000	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0.000000	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,098,130	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,599,291	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,499,479	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	26,438,766	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,491,803	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,542,815	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,937,154	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	755,491	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	931,347	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,730,698	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,277,203	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,680,647	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	2,613,035	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	853,342	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,492,461	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,918,135	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	186,496,804		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	233,843	0	0	0	50.00
50.01	05001	OPERATING ROOM	0.000000	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	77,928	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	60,568	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	100,615	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	20,154	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,264	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,928	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	23,071	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	89,384	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	73,264	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		688,019	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.093288	0	388,941	0	0	50.00
50.01	05001	OPERATING ROOM	0.000000	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.266189	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.416104	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111814	0	579,252	0	0	54.00
60.00	06000	LABORATORY	0.158078	0	455,269	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.219542	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.617736	0	88,639	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244774	0	99,840	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.414393	0	33,481	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000180	0	17,824	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.384996	0	63,220	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286916	0	98,430	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187852	0	524,700	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.358153	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.221018	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.106365	0	802,971	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.443696	0	263,047	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.374190	0	443,059			95.00
200.00		Subtotal (see instructions)		0	3,858,673	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	3,858,673	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	36,284	0		50.00
50.01	05001	OPERATING ROOM	0	0		50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,768	0		54.00
60.00	06000	LABORATORY	71,968	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	54,756	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	24,438	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,874	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,339	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,241	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,566	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	85,408	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	116,713	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	165,788			95.00
200.00		Subtotal (see instructions)	785,146	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	785,146	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,123	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,123	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)	4,355	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)	1,227	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)	9,093,912	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)	9,093,912	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)	9,093,912	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)	1,485.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,822,353	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)	1,822,353	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,596,289	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,418,642	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)	227,780	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	146,693	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	374,473	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,044,169	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,768	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,485.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,625,851	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,136,682	9,093,912	0.124994	2,625,851	328,216	90.00
91.00	Nursing School cost	0	9,093,912	0.000000	2,625,851	0	91.00
92.00	Allied health cost	0	9,093,912	0.000000	2,625,851	0	92.00
93.00	All other Medical Education	0	9,093,912	0.000000	2,625,851	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,123	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,123	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)	4,355	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)	67	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)	619	15.00
16.00	Nursery days (title V or XIX only)	20	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)	9,093,912	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)	9,093,912	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)	9,093,912	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)	1,485.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	99,509	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)	99,509	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	294,767	619	476.20	20	9,524	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	104,107	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	213,140	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)	12,916	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,636	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	22,552	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	190,588	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,768	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,485.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,625,851	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,136,682	9,093,912	0.124994	2,625,851	328,216	90.00
91.00	Nursing School cost	0	9,093,912	0.000000	2,625,851	0	91.00
92.00	Allied health cost	0	9,093,912	0.000000	2,625,851	0	92.00
93.00	All other Medical Education	0	9,093,912	0.000000	2,625,851	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,515,679		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094135	1,469,782	138,358	50.00
50.01	05001	OPERATING ROOM	0.000000	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.266189	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.416104	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111814	1,320,659	147,668	54.00
60.00	06000	LABORATORY	0.158078	1,494,243	236,207	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.219542	562,405	123,472	65.00
66.00	06600	PHYSICAL THERAPY	0.617736	192,119	118,679	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244774	75,652	18,518	67.00
68.00	06800	SPEECH PATHOLOGY	0.414393	13,555	5,617	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000180	230,487	41	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.384996	526,080	202,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286916	691,574	198,424	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187852	1,453,769	273,093	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.358153	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.221018	0	0	90.00
91.00	09100	EMERGENCY	0.106365	1,256,742	133,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.443696	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,287,067	1,596,289	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)		9,287,067		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/26/2020 11:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		143,638		30.00
43.00	04300	NURSERY		32,933		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094135	233,843	22,013	50.00
50.01	05001	OPERATING ROOM	0.000000	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.266189	77,928	20,744	52.00
53.00	05300	ANESTHESIOLOGY	0.416104	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111814	60,568	6,772	54.00
60.00	06000	LABORATORY	0.158078	100,615	15,905	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.219542	20,154	4,425	65.00
66.00	06600	PHYSICAL THERAPY	0.617736	1,264	781	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244774	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.414393	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000180	7,928	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.384996	23,071	8,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286916	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187852	89,384	16,791	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.358153	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.221018	0	0	90.00
91.00	09100	EMERGENCY	0.106365	73,264	7,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.443696	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		688,019	104,107	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)		688,019		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/26/2020 11:24 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,031,947	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	673,517	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	3,624,533	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	30.91	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.26	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.46	31.00
32.00	Sum of lines 30 and 31	26.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.26	33.00
34.00	Disproportionate share adjustment (see instructions)	76,159	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/26/2020 11:24 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000077451	0.000092584	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	640,742	773,132	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	479,240	194,339	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	673,579		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
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,455,202		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	3,455,202	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	216,330	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	3,671,532	59.00
60.00	Primary payer payments	14,873	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	3,656,659	61.00
62.00	Deductibles billed to program beneficiaries	492,237	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	28,018	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	18,212	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,770	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,182,634	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	24,370	70.93
70.94	HRR adjustment amount (see instructions)	-7,856	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/26/2020 11:24 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	416,738	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)	2020	133,334	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		42,224	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,706,996	71.00
71.01	Sequestration adjustment (see instructions)		74,140	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		3,641,828	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)		-8,972	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		61,402	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/26/2020 11:24 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,042,388	2.00
3.00	OPPS payments	3,565,052	3.00
4.00	Outlier payment (see instructions)	18,263	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.859	5.00
6.00	Line 2 times line 5	3,472,411	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	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)	3,583,315	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)	701,776	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)	2,881,539	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)	2,881,539	30.00
31.00	Primary payer payments	334	31.00
32.00	Subtotal (line 30 minus line 31)	2,881,205	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)	41,933	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	27,256	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,585	36.00
37.00	Subtotal (see instructions)	2,908,461	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)	2,908,461	40.00
40.01	Sequestration adjustment (see instructions)	58,169	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	2,810,956	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)	39,336	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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 6/26/2020 11:24 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,641,828		2,810,956	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)		3,641,828		2,810,956	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		39,336	6.01
6.02	SETTLEMENT TO PROGRAM		8,972		0	6.02
7.00	Total Medicare program liability (see instructions)		3,632,856		2,850,292	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: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/26/2020 11:24 am
	Title XVIII	Hospital	PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/26/2020 11:24 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,324	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	23,710,836	0	0	0	4.00
5.00	Other receivable	1,437,289	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,170,672	0	0	0	6.00
7.00	Inventory	538,815	0	0	0	7.00
8.00	Prepaid expenses	60,825	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-7,008,059	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,571,358	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	625,461	0	0	0	13.00
14.00	Accumulated depreciation	-400,927	0	0	0	14.00
15.00	Buildings	9,260,360	0	0	0	15.00
16.00	Accumulated depreciation	-1,783,316	0	0	0	16.00
17.00	Leasehold improvements	278,530	0	0	0	17.00
18.00	Accumulated depreciation	-195,115	0	0	0	18.00
19.00	Fixed equipment	343,428	0	0	0	19.00
20.00	Accumulated depreciation	-269,893	0	0	0	20.00
21.00	Automobiles and trucks	1,659,549	0	0	0	21.00
22.00	Accumulated depreciation	-989,835	0	0	0	22.00
23.00	Major movable equipment	10,957,794	0	0	0	23.00
24.00	Accumulated depreciation	-8,785,677	0	0	0	24.00
25.00	Minor equipment depreciable	1,626,370	0	0	0	25.00
26.00	Accumulated depreciation	-788,235	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	917,459	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,455,953	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	40,854,472	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	246,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,100,472	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58,127,783	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,857,414	0	0	0	37.00
38.00	Salaries, wages, and fees payable	998,465	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	51,736	0	0	0	40.00
41.00	Deferred income	10	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	51,522	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,959,147	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	36,568	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	36,568	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,995,715	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	55,132,068				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)	55,132,068	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,127,783	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/26/2020 11:24 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		41,331,420		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,128,763				2.00
3.00	Total (sum of line 1 and line 2)		54,460,183		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFERS	1,864,230		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)		1,864,230		0		10.00
11.00	Subtotal (line 3 plus line 10)		56,324,413		0		11.00
12.00	ASSET TRANSFERS	22,474		0		0	12.00
13.00	DEDUCTIONS	1,169,868		0		0	13.00
14.00	ROUNDING	3		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1,192,345		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		55,132,068		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	TRANSFERS		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	ASSET TRANSFERS		0			12.00
13.00	DEDUCTIONS		0			13.00
14.00	ROUNDING		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: 15-0091 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/26/2020 11:24 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,601,778		8,601,778	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,601,778		8,601,778	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,601,778		8,601,778	17.00
18.00	Ancillary services	40,177,053	0	40,177,053	18.00
19.00	Outpatient services	0	154,887,185	154,887,185	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	17,245,741	17,245,741	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	48,778,831	172,132,926	220,911,757	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		59,440,382		29.00
30.00	PROVISION FOR B/D	6,987,922			30.00
31.00	HOME OFFICE INTEREST EXPENSE	654,354			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)		7,642,276		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)		67,082,658		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Prepared: 6/26/2020 11:24 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	220,911,757	1.00
2.00	Less contractual allowances and discounts on patients' accounts	146,464,297	2.00
3.00	Net patient revenues (line 1 minus line 2)	74,447,460	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	67,082,658	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,364,802	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	4,523,013	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	181,936	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	EMS SUBSIDY	467,397	24.00
24.01	OTHER OPERATING REVENUE	591,615	24.01
25.00	Total other income (sum of lines 6-24)	5,763,961	25.00
26.00	Total (line 5 plus line 25)	13,128,763	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)	13,128,763	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 6/26/2020 11:24 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	214,495	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,835	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)	12.40	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	216,330	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